LONG-TERM CARE STUDY

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Regulation and Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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Introduction

In 2018, the Council of the District of Columbia passed the Study of Long-Term Care Facilities and Long-Term Care Services Act of 2018. This Act directed DC Health to collaborate with other District agencies and community partners to assess the availability of affordable long-term care facilities and long-term care services in the District. This report would also discuss any changes in future needs for those services and supports for District residents. In accordance with this law, the Health Regulation and Licensing Administration (HRLA), the administration responsible for regulatory oversight of healthcare facilities and professionals under DC Health, assembled existing data for the period of 2018 through 2020 and conducted community-based participatory research, including surveys and focus groups, to explore the following:

- The availability of affordable long-term care facilities, e.g., nursing homes, assisted living residences, and community residences in the District;
- The number of beds available for the long-term care facilities in the District, as well as the payment sources accepted for those services;
- The types of long-term care services and supports for seniors;
- An estimate of the number of District residents receiving long term care services and supports from facilities in Maryland and Virginia;
- The number of District residents receiving long-term care services who transitioned in the preceding year to a long-term care facility either within or outside the District; and
- An estimate of the number of District residents who may require facility-based, home, and community-based long-term care services over the next 10 years.

Using the data collected and the estimated population growth in the District of Columbia among senior residents, projections were determined for the number of residents with the potential need for long-term care services over the next 10-year period. Included in this report are recommendations for the resources and financial sources required to ensure residents have access to affordable long-term care services in the District.

Executive Summary

The District has many programs that enable its residents to obtain affordable long-term care. The continued collaboration and coordination of agencies with an oversight responsibility over long-term care is critical to meeting the needs of the impending older population and future surges. Although long-term supports and services can promote and prolong aging in place, the current capacity of long-term care facilities is not sufficient for the anticipated older adult population in coming years. There is also a portion of this demographic whose care management is complex so it will supersede the services and supports in the community and in turn will have to be managed in a facility.

The long-term care services assessed in this report include nursing homes, community residential facilities, assisted living residences, and home health care in the District, as well as services District residents receive in Maryland or Virginia. The data collection included an examination of the cost and availability of beds in nursing homes and assisted living facilities from 2018 to 2020. This assessment is critical to the District's older adults, 65 years and older, whose population is estimated to reach 104,193 by 2030.[1] DC Health's analysis determined the following:

- The District has lost 439 nursing facility beds in the last decade due to the closure and conversion of health and rehabilitation facilities and changes in room occupancy per the request of the provider (e.g., double occupancy to single).;
- Medicaid does not cover the total cost of assisted living facility care, e.g., room and board, and at the time of the initial study data collection (2018-2020) there were limited assisted living residences that accepted Medicaid payment. Since 2020, one assisted living residence that accepted Medicaid payment closed; however, two new providers have opened that accept Medicaid;

[1] District of Columbia State Data Center. (2019). Population Forecast Summary. https://planning.dc.gov/publication/dc-forecasts

- District agencies are meeting the demand for most residents needing long-term care services and support, with 97 percent of District residents having some form of coverage to pay for services.
- The District does not have long term care facilities with the necessary programs for persons with challenging psychiatric behaviors and complex health interventions;
- Unanticipated costs associated with the COVID-19 pandemic led to Medicaid payment rate increases in assisted living facilities and nursing facilities – however, these increases were temporary and did not address long-standing reimbursement concerns;
- During and post the COVID-19 pandemic, healthcare workforce shortages increased across service areas, especially for home health aides and in-home support services; and
- Due to the chronic disease burden on the increasing aging population, an increased number of the population will require long-term care and support, with an estimated 10.8 percent of the total population being 65 or older and 70 percent of those 65 or older requiring long-term care by 2030.[2] After reviewing the results of this study, the following conclusions were noted:

The District is not exempt from the national healthcare workforce shortage. While healthcare staffing challenges were present before the COVID-19 pandemic, the decrease in the workforce is more pronounced and on a broader scale after the COVID-19 pandemic. Creative strategies should be explored to retain existing healthcare workers and to attract new staff to the healthcare field. One such strategy could include a study on the utilization, work hours, in addition to pay rates for home health aides to better understand workplace barriers. This type of study is being considered by the DC Health Care Finance Department.

[2] (According to the Administration on Aging and Community Living, an individual 65 or older has a 70% chance of requiring long-term care.) *6 Aging and Community Living (2020). How Much Care Will You Need. Available at: https://acl.gov/ltc/basic-needs/how-much-care-will-you-need*

DC Health has begun identifying and implementing solutions to address healthcare workforce shortages. The recent expansion of the Health Professional Loan Repayment Program to include part-time participants, private sites, and new subspecialities is another strategy to enhance the medical, dental, nursing, and social workforce. Looking further upstream, DC Health is creating a scholarship for prospective health professionals and collaborating with schools to improve and expand training programs. DC Health's new scholarship program, the High Needs Scholarship Program, to attract and train entry level health care workers such as home health aides, certified nursing assistants, and emergency medical technicians.

The District's Long-Term Care Services

Long term care services include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. These supports and services can be provided at home, in the community, in an assisted living facility or in a skilled/non-skilled nursing home. Services typically germane to long term care may be needed at any age. Payment for these services may include Medicare, Medicaid, private pay and long-term care insurance depending on the individual's level of care, and the type of health care services. This report does not include services for individuals with intellectual disabilities.

District residents can receive long-term care services that include the following options: 1) services and supports received at a long-term care facility, 2) services provided to residents in the community who meet a nursing home level of care such as home health care through the Medicaid Elderly and Persons with Physical Disabilities Waiver (EPD), or 3) residents who are not nursing home level of care may receive home health aide services in their place of residence.

Personal and health care services specific to long-term care discussed in this section include nursing homes, community residential facilities, assisted living residences, and home health care located in the District, as well as the services some District residents receive in Maryland or Virginia. Information presented includes the numbers of residents receiving the various types of services and payment for those services, as well as a summary of the cost of nursing homes and assisted living residences in the years 2018, 2019, and 2020. Also, described are the unanticipated costs associated with the COVID-19 protocols and procedures, adopted by the District as measures to keep patients healthy and safe.

In 2019, the District was home to approximately 83,600 older adults, with a projection that the population could rise by 24.4 percent by 2030.[3] Approximately 74.1 percent of seniors live alone or 61,900 individuals. In comparison, 23 percent of residents aged 64 and younger live by themselves. With a high percentage of District residents living

[3] https://www.dccouncilbudget.com/olderadultsindc

alone, and physical limitations increase with age, there would be a need for community supports for people in this category.[4]

DC Health Care Finance Administration (DHCF) maintains data on the number of Medicaid beneficiaries and the percentage that are elderly and disabled receiving a long-term care service. During calendar years 2018 thru 2020, 22 percent of Medicaid beneficiaries were elderly and disabled persons. The District's overall Medicaid expenditures for the aforementioned population was 58 percent during 2018 and 2019, and 59 percent in 2020.[5]

Nursing Facilities

In the District, nursing facilities operate under federal and state regulations. Locally, these facilities are governed by Title 22B DCMR chapter 32, which defines a nursing facility as a 24-hour institution or distinct part of a 24-hour institution that: (1) is primarily engaged in providing nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of persons who are injured, disabled, or sick; (2) is not primarily for the care and treatment of mental diseases; and (3) has in effect a transfer agreement that meets the requirements of 42 U.S.C. § 1395 with one (1) or more hospitals that have a provider agreement in effect that meets the requirements of 42 U.S.C. § 1395.[6] Skilled services offered in District nursing facilities include, but are not limited to, ventilation/respiratory support, central line management, gastric tube feeds, occupational therapy, physical therapy, speech therapy, wound care, diabetes management, recreational therapy, dental services, podiatry services, respite care, Alzheimer's/dementia care, and hospice.

[4] Ibid

[5] DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility and claims with dates of service in CYs 2018-2020.

[6] District of Columbia Municipal Regulations. Title 22 Chapter 32 Nursing Facilities. https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Nursing_%20Homes_%20Regulations.pdf

Available Beds

Beginning in Fiscal Year 2021 (October 1, 2020), there were 19 licensed nursing facilities in the District inclusive of 2,594 licensed beds. However, two nursing facilities closed in February 2021, remaining were 2,447 licensed nursing facility beds available in the District. Hence, there were 17 nursing facilities, of which 16 provided skilled nursing services, and one provided non-skilled services. One of the 17 skilled nursing facilities was for pediatric care. Included in the 2,447 licensed nursing facility beds in the District were 56 memory care beds, of which 33 were located at Forest Hills of DC and 23 were located at Knollwood HSC. Based on a survey conducted in 2021 of the District nursing facilities, only four were at capacity and had wait lists. During June 2021, there were a total of 1,815 District residents in nursing facilities; and of that total, 1,375 were in facilities located in the District.

Within the last decade, the District has lost approximately 439 nursing facility beds. The loss of beds can be attributed to the closure and conversion of health and rehab facilities at Thomas Circle, United Medical Nursing Home, and the Washington Home. Other facilities have experienced downsizing to maintain COVID-19 precautions. For example, Knollwood HSC converted to single occupancy rooms reducing capacity from 73 beds to 49 beds on September 8, 2020. Bridgepoint Sub-Acute and Rehab National Harborside increased from 124 to 125 licensed beds on December 17, 2021. The total number of licensed skilled/non-skilled nursing home beds as of December 31, 2021, was 2,448. Other contributing factors to the loss of facilities are changes in occupancy and business costs.

Payment Rates and Sources

The largest benefactor for the financing of nursing homes is Medicaid. Each state is responsible for determining the parameters for the Medicaid rate in nursing facilities, and these conditions have direct implications for nursing home operational budgets. Medicaid nursing facility services are available only when other payment options are unavailable and the individual is eligible for the Medicaid program[7].

[7] https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html

Medicaid, a health insurance program administered by the Department of Health Care Finance (DHCF) for low-income individuals, is accepted by all nursing facilities in the District. Medicaid, which is comprised of state and federal funds, employs the Resource Utilization Group (RUG) scoring system. The RUG system is a mechanism to calculate the cost of care, which is contingent upon the level of care provided to residents in nursing facilities. Data gathered by the Centers for Medicare and Medicaid Services (CMS) reports a total of 246,108 Medicaid beneficiaries in the District as of January 2021. Figure 1 provides comparisons in the trend of the rates between small, large, and hospital-based skilled nursing facilities in the District for Medicaid beneficiaries. Large facilities are lower in cost overall, and hospital-based facilities are highest in cost.

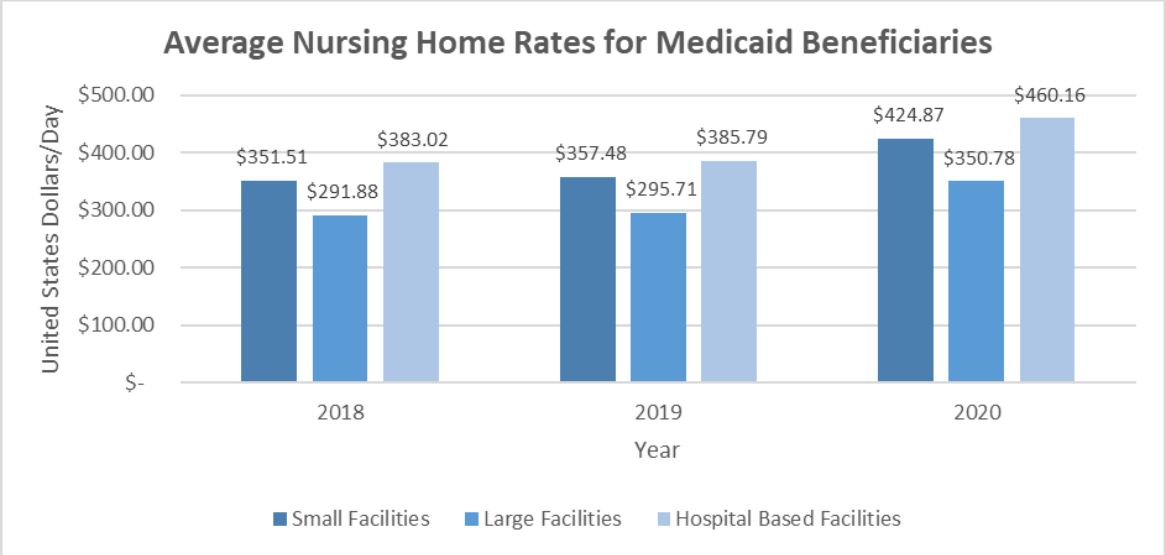

Figure 1

DHCF also provides additional funds to facilities that are able to care for special populations requiring mechanical ventilation, bariatric care, and behavioral management procedures. The cost of a bed at a skilled nursing facility is contingent upon many factors. The average cost of a bed in a nursing facility in the District for private pay is slightly higher than the Medicaid rate displayed in Figure 1, approximately $537.13 per day based on a survey of nursing facilities administered in 2021. The aforementioned rate is based on a standard room, although some facilities offer deluxe and private rooms at an upcharge. Costs are regularly affected by supply and demand, special services needed, higher care needs, and length of stay.

There are two facilities that do not accept Medicare, the pediatric and the one non-skilled facility. During June 2021, a survey of six open-ended questions was developed and distributed to the long-term care facilities in the District to assess the forms of payments accepted, base rate, the number of beds available, intake/admission process, and services/amenities offered at the facility. The District of Columbia Health Care Association facilitated the distribution to its member facilities to maximize participation. The survey results corroborated with data on nursing homes collected by CMS found that 88 percent of facilities in the District accept both Medicare and Medicaid compared to 7 percent, or two facilities, that do not accept Medicare. Private pay is accepted by 88 percent of facilities in the District. On average, the base rate is $9,132.30 per month for private pay and increases when a resident requires skilled services in the facilities according to the responses received when the survey was administered. See Figure 2.

Survey Results – DC Nursing Facilities

Capabilities	Carroll Manor	Forest Hills	HSC	Deanwood	Ingleside	Jean Jugan Residence	Lisner Louise	Serenity	Sibley Renaissance	Unique	Stoddard Baptist	Inspire	Knollwood	Washington Center for Aging Services	Capitol City	Bridgepoint National Harbor	Bridgepoint Capitol Hill
Private Pay	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES
Medicare	YES	YES	NO	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Medicaid	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
BaseRate/day**	$419	$ 422.30	$ 1,244	$390	$525	$375	$350	$331	$ 1,750	$331	$360	$331	$471	$450	$382	$500	$500
Rate contingent on skilled services	YES	NO	YES	NO	NO	NO	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	NO
Licensed Beds	240	141	16	296	34	40	60	183	45	230	164	180	49	258	360	124	117
Waitlist	NO	NO	NO	NO	YES	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO
Beds by Payor Type	NO	NO	NO	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
Physical therapy/ Occupational therapy/ Speech	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Dialysis	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	YES	NO	YES*
Memory Care	NO	YES	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	NO	NO
Specialty Services	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Referral Required for Admission	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES

**Lowest rate available for semi-private or standard room

Figure *2*

Transition from Home to Nursing Facility

According to data provided by DHCF, a total of 1,557 residents receiving personal care services at home transitioned to a nursing facility within six months of initiating home care between 2018 through 2020. Personal care services include dressing, eating, toileting, and other activities of daily living. The data over a three-year period reflects the transition from persons receiving long term care services in the home moving to a facility setting is trending downward (Figure 3).

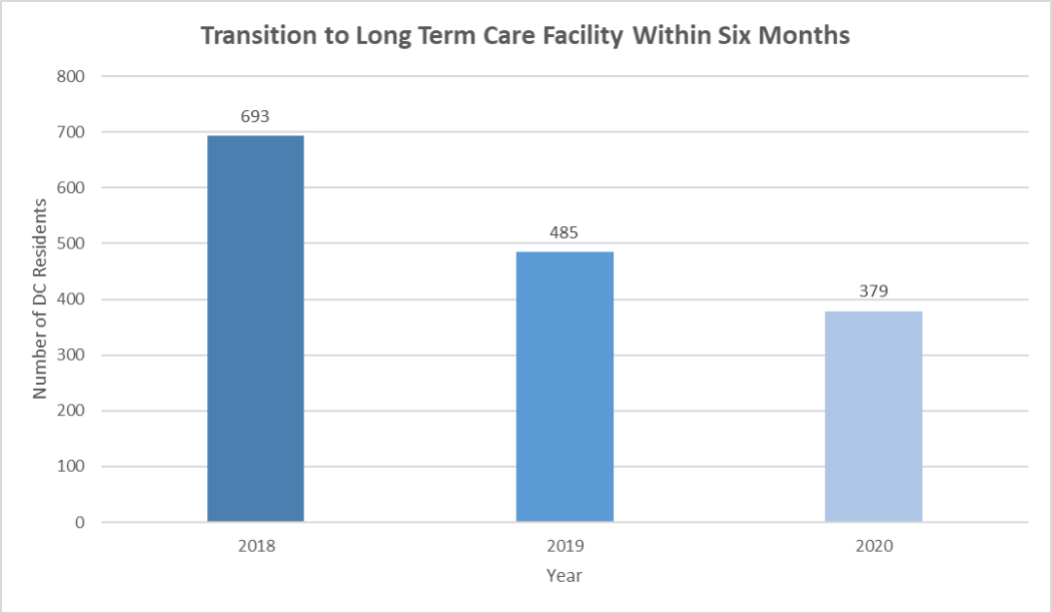

Figure 3

District Residents in Maryland or Virginia Facilities

As of January 1, 2021, there were 53 nursing facilities enrolled in the DC Medicaid program. Of those 53 facilities, 31 were in Maryland, 3 were in Virginia, and 19 were in the District. According to DHCF, as of June 2021, 440 of the total beneficiaries receiving benefits through enrollment in Fee-for-Service Medicaid under § 1815 of the Social Security Act (42 U.S. Code § 1395g) were in nursing facilities in Maryland. There were no DC residents in facilities in Virginia. The DHCF has the authority for monitoring and oversight of District residents placed in out of state nursing facilities e.g., Maryland and Virginia. Through 2021, Cigna and United Healthcare Medicare Advantage plans maintained contracts with 39 skilled nursing facilities in Maryland to provide coordinated services for DC residents eligible for Medicare and Medicaid through the Dual Eligible Special Needs Plan (D-SNP). District beneficiaries admitted to a Medicare certified nursing facility, who are insured by a Medicare Advantage plan, DCHF will cover the co-payment for those with D-SNP.

Community-Based Settings

The District's Olmstead Community Integration Plan describes the initiatives and supports for residents with disabilities to live in the community in the most integrated setting possible in accordance with the Americans with Disabilities Act. It unifies the

purviews of the District agencies and minimizes silos in the system through partnerships that facilitate the delivery of information. The three priority areas are housing, employment, and health and wellness.[8] Each service follows a respective algorithm to assess the patient, connect the patient with appropriate supports, and facilitate the transition to the ideal setting.

In 2021, DHCF reported there were 1,522 beneficiaries of care provided by community-based facilities. This number reflects the total beneficiaries in all types of community-based facilities as grouped together by the DHCF under assisted living residences and may also include those facilities managed under the Department of Disability Services (DDS). DC Health license and categorize two types of community-based facilities, explored in this report, that service residents of the District: community-based residential facilities and assisted living facilities. The two are differentiated by the level of independence of the resident; the more independent resident may be in a community-based residence facility.

COMMUNITY RESIDENTIAL FACILITY

Community residence facility (CRF) means a facility that provides a sheltered living environment for individuals who desire or need such an environment because of their physical, mental, familial, social, or other circumstances, and who are not in the custody of the Department of Corrections. All residents of a community residence facility shall be 18 years of age or older, except that, in the case of group homes for persons with intellectual disabilities, no minimum age shall apply, unless this requirement is waived in accordance with [§ 44-505I].[9] Residents admitted to a CRF, are certified by a physician that there is a need of professional nursing care and can be assisted safely.

ASSISTED LIVING RESIDENCE

Assisted Living Residence" or "ALR" means an entity, whether public or private, for profit or not for profit, that combines housing, health, and personalized assistance, in

[8] District of Columbia, Office of Disability Rights. (2022, April 29). DC—One Community for All: Olmstead Community Integration Plan Calendar Years 2021-2024. https://odr.dc.gov/sites/default/files/dc/sites/odr/page_content/attachments/2021-2024%20District%20Olmstead%20Plan%204-29-22.pdf

[9] https://code.dccouncil.gov/us/dc/council/code/sections/44-501

accordance to individually developed service plans, for the support of individuals who are unrelated to the owner or operator of the entity. “Assisted Living Residence” or “ALR” does not include a group home for persons with intellectual disabilities as defined in DC Official Code § 44-501(5) or a mental health community residence facility as that term is used in Chapter 38 of Title 22 of the District of Columbia Municipal Regulations.[10]

Persons residing in an ALR are provided care and services to promote an independent quality of life and to age in place. If it’s determined the resident requires assistance the ALR shall offer or coordinate for payment 24-hour supervision, assistance with scheduled and unscheduled activities of daily living, and instrumental activities of daily living as needed, as well as provision or coordination of recreational and social activities and health services in a way that promotes optimum dignity and independence for the residents.

Available Beds

COMMUNITY RESIDENTIAL FACILITY

With the introduction of ALRs, some CRFs converted to assisted living facilities. During the time of this report in 2021, there was 1 CRF. The facility was licensed for eight beds.

ASSISTED LIVING RESIDENCE

During 2021, there were 13 assisted living residences in the District; and four of them have contracts with DHCF to offer services for Medicaid beneficiaries. The remainder were private pay facilities. The capacity was 950 beds.

Payment Rates and Sources

The programs that fund these services include Home and Community-Based Services (HCBS), EPD Waiver, Home Health, and Medicaid State Plan Services. Many of the beds in the community-based residence facilities are private pay.

Only five assisted living residences in the District accepted Medicaid as a payment source as of October 2021 for clinical services. There are two more affordable assisted

[10] § 44–102.01. Definitions.

living residences in the pipeline to open in 2022. In 2018, DHCF reported that the average cost per day of an assisted living residence for a Medicaid beneficiary was $157.78 per day[11] (Figure 4).

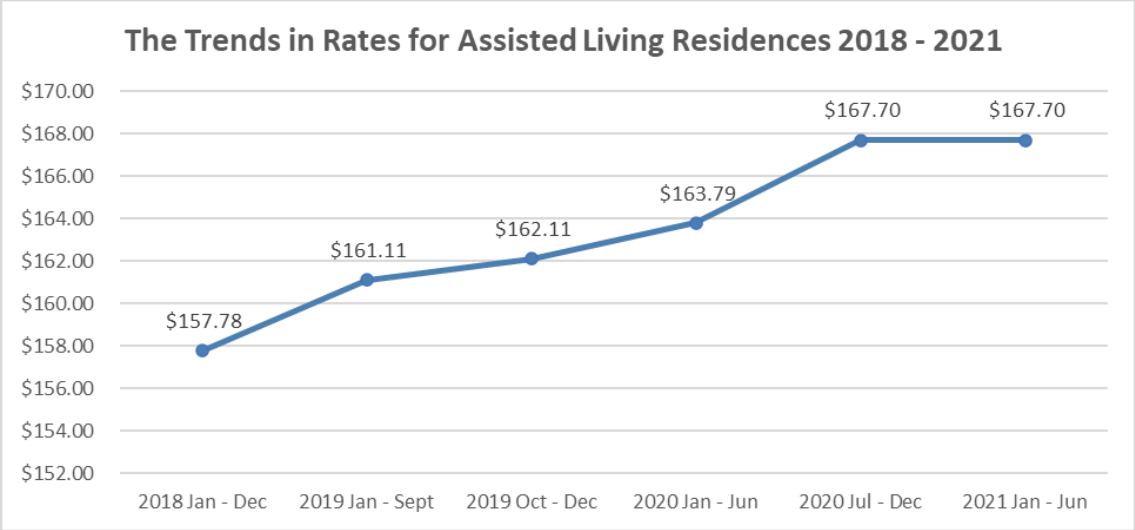

Figure 4

[11] District of Columbia, Department of Health Care Finance. (2020). DC Medicaid Bulletin, 14(4). https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/24034

Long-Term Support Services

Several District agencies provide long-term support services throughout the eight wards of the District. These services provide additional support to Medicaid beneficiaries receiving care in the home, assisted living, or community facilities. Medicaid funding contributes significantly to these home and community-based services (HCBS). DHCF offers the EPD waiver program which sources case management, adult day health programs, personal care services, respite care, community transition services, environmental accessibility adaptation, and participant directed services.[12] This report will focus on the services provided to beneficiaries of the EPD waiver. The other two HCBS waiver programs are operated and implemented by DDS: Individuals and Family Support (IFS) waiver and Intellectual and/or Developmental Disabilities (I/DD) waiver.

The annual budget of $47.9 million is comprised of 79 percent District funds and 21 percent federal funds to support DC Department of Aging and Community Living (DACL) programs and services. Medicaid funds pay for beneficiaries who wish to remain at home or in assisted living if they can obtain the care at a lower cost than in a nursing home through Waiver Funded Services or HCBSs. The State Plan also reviews the District's efforts to improve the senior services delivery system by funneling provisions from the Older Americans Act to the Senior Service Network, a network of 22 community-based organizations that provide 40 programs surrounding legal, nutrition, social, and health services throughout the city. DACL is also responsible for the Aging and Disability Resource Center, which provides information, counseling, and service access to those seeking District Long-Term Support Services (LTSS). Figure 5 illustrates the number of residents served by the various services provided in the District in Fiscal Year 2017.

[12] District of Columbia, Department of Healthcare Finance. EPD Waiver Services. https://dhcf.dc.gov/page/epd-waiver-services

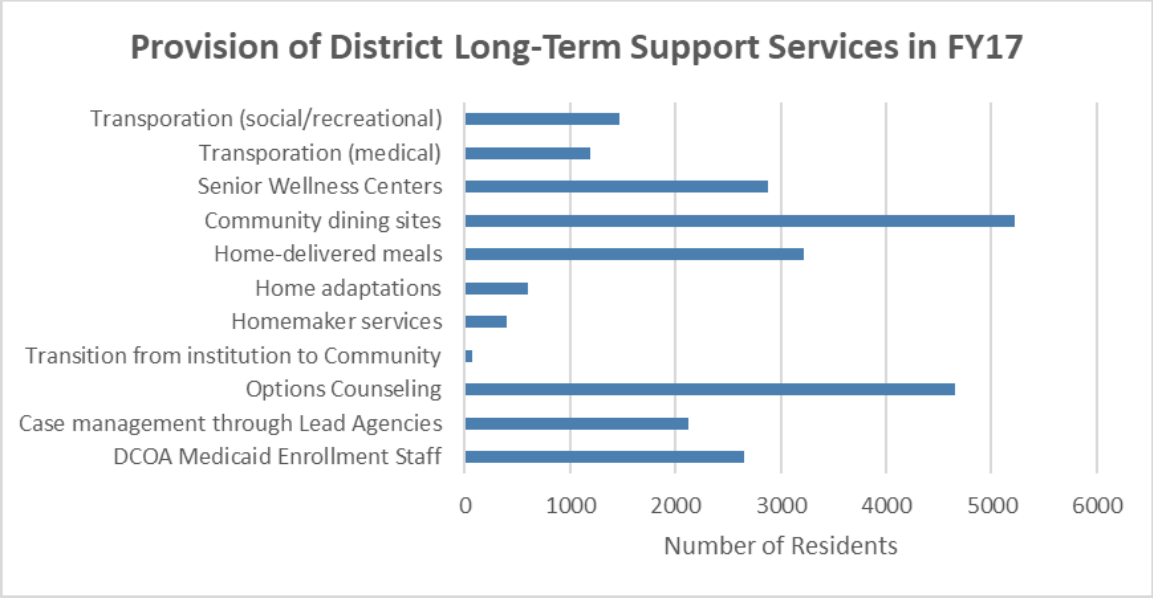

Figure 5[13]

Safe At Home Program

Through partnerships with the District of Columbia Department of Housing and Community Development (DHCD), DACL offers The Safe at Home Program. The program is intended to increase one's safety at home by reducing risks for injury by providing minor home modifications and adaptive equipment to those most vulnerable, like frail seniors and disabled adults. These services reinforce the growing sentiment that older adults should receive care while remaining in their homes. The most recent data for the number of residents receiving support services is from 2017 as displayed in Figure 5.[14]

Nutrition Assistance

DACL's nutrition programs serve eligible seniors 60+ and adults with disabilities either at one of the more than 40 community dining sites across all eight wards or through home-delivered meals. DACL also offers nutrition counseling and nutrition education through registered and licensed dietitians and other health professionals. Nutrition programs are funded by the Older Americans Act.

[13] DCOA State Plan on Aging 2019 to 2022_FINAL DRAFT_CLEAN_5.21.2018.pdf
[14] District of Columbia, Office on Aging. 2019-2022 District of Columbia State Plan on Aging. https://dcoa.dc.gov/sites/default/files/dc/sites/dcoa/page_content/attachments/DCOA%20State%20Plan%20on%20Aging%202019%20to%202022_FINAL%20DRAFT_CLEAN_%205.21.2018.pdf

Senior Wellness Centers

Through Title III, DCOA funds six Senior Wellness Centers (SWCs) in Wards 1, 4, 5, 6, 7, and 8. These centers provide comprehensive programs that promote the health of seniors in the District and help ensure they remain in communities they know and love. Increasing access to health services is a priority for the District. The government has invested $4 million in equity funding for all internal renovations and upgrades of SWCs to allow more seniors to participate. DCOA is also funding a satellite health pilot program for Wards 2 and 3 that do not have physical SWCs. SWCs help older residents take charge of their health, wellness, and social life. Wellness Centers offer daily activities, group lunches, exercise equipment, computer labs, and a friendly atmosphere to keep residents healthy, connected, and thriving.

Adult Day Health Program (ADHP)

ADHP services are designed to encourage older adults to live in the community by offering non-residential medical supports and supervised therapeutic activities in an integrated community setting. ADHPs also foster opportunities for community inclusion. Services provided at ADHPs may include:

- Nursing services
- Individual and group therapeutic activities
- Socialization
- Individual and group counseling
- Personal Care Aide (PCA) services
- Medication administration
- Meals, snacks, and nutritional supports
- Art and music therapies
- Barber and beauty services
- Transportation for off-site services

Personal Care Services

In Fiscal Year 2020, over 4,900 District residents received personal care services. Personal care services include a wide array of routine activities that enable the Medicaid beneficiary to remain in their home. The services include:

- Cueing or hands-on assistance with basic personal care, including bathing, grooming, and assisting with using the toilet or bedpan
- Assistance with continence care, including changing protective under-garments.
- Assistance with transfers, ambulation
- Reading and recording vital signs such as temperature, heart rate, and respiration rate
- Observing and monitoring changes in physical condition, behavior, or appearance
- Meal preparation and assistance with eating
- Infection control
- Assistance with maintaining the home in order to maintain health, safety, and comfort
- Accompaniment to medical appointments, employment, or approved activities.
- Shopping for nutrition and other health-related items
- Assistance with telephone use
- Assisting with self-administration of medication

In 2021, there were over 8,000 licensed home health aides in the District providing personal care services. The six to seven home health aide training programs graduate about 400 candidates each year who are eligible for the home health aide certification. The home health aides can provide additional skilled services as required, such as range of motion exercises, blood pressure, and ostomy care.[15]

[15] Department of Health. Notice of Final Rulemaking on Title 17 Chapter 93 Health Home Health Aide Regulations. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Home%20Health%20Aide%20Regulations%20-%20Final%209-29-2017_0.pdf

Managed Care Organizations

In 1994, the District initiated a charge to promote managed care in the Medicaid program. The Office of Managed Care, within DHCF, was formed to ensure compliance and monitor the performance of the contracted Managed Care Organizations (MCO) and their obligation to deliver appropriate, timely, and quality care to beneficiaries. Historically, most DC Medicaid beneficiaries receive care through Medicaid managed care. In 2020, DHCF expanded the Medicaid managed care program by transitioning nearly 16,000 Medicaid beneficiaries from "fee-for-service" (FFS) Medicaid to the Medicaid managed-care program. Today, over 80 percent of DC Medicaid beneficiaries are enrolled in the Medicaid managed care programs. Expanding managed care to more Medicaid beneficiaries provides residents access to care coordination, case management, and other benefits not available in the FFS program. By expanding the Medicaid managed care program, the District can reduce Medicaid program costs, better manage utilization of health services, and potentially save the city millions in health care spending. Services to Medicaid beneficiaries are provided by three MCOs: AmeriHealth Caritas DC, CareFirst Community Health Plan of DC, and MedStar Family Choice, which are contracted with the 44 skilled nursing facilities across the District, Maryland, and Virginia. These MCOs also cover the first 90 days of skilled services. For stays longer than 90 days or custodial services, they are converted to Medicaid FFS. While a patient is in the MCO, the MCO is responsible for all services including care coordination.[16]

In addition, the District Dual Choice program is exclusively for dually eligible beneficiaries and aims to better coordinate their Medicare (Parts A, B, and D) and Medicaid benefits. Through 2021, Cigna and UnitedHealthcare maintained Medicare contracts with two skilled nursing facilities in the District to provide coordinated services for persons eligible for Medicare and Medicaid through the Dual Eligible Special Needs Plan (D-SNP). Currently, UnitedHealthcare operates an expanded model under Dual Choice which covers and finances all Medicare and Medicaid benefits, including nursing facility care, EPD Waiver services, and more. DHCF reports there are approximately

[16] District of Columbia, Department of Health Care Finance. (2020, January 30). Medicaid Managed Care Quality Strategy. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20Medicaid%20Managed%20Care%20Quality%20Strategy%202020.pdf

13,000 currently enrolled in Dual Choice and over 40,000 District residents with Medicare and some form of Medicaid coverage.

Resources for Long-Term Care Services

District agencies are meeting the demand for long-term care services and support with 97 percent of District residents insured to maximize accessibility to LTSS. The existing District agencies have a multitude of programs to support accessibility for Medicaid beneficiaries included in this demographic. These programs include Medicaid FFS, EPD waiver, Program of All-Inclusive Care for the Elderly (PACE), and Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP).[17]

Medicaid Fee-For-Service

Medicaid pays healthcare providers directly for provided services through the Medicaid FFS program. All medical care is covered, including doctor visits, hospital care, and prescriptions. The program also covers other benefits like dental, hearing aids, and long-term care. A copayment may be required for prescribed medications.

Medicaid Elderly and People with Disabilities Waiver

Through the fee-for-service EPD Waiver, Medicaid pays healthcare providers directly for provided services. All medical care is covered, including doctor visits, hospital care, and prescriptions. The program also covers other benefits like dental, hearing aids, and long-term care. It also includes case management, assisted living, and participant-directed services. A copayment may be required for prescribed medications.

Program of All-Inclusive Care for the Elderly (PACE)

Under this program, Medicaid pays a PACE organization to deliver and manage Medicare and Medicaid benefits for enrollees. All medical care is covered, including doctor visits, hospital care, and prescriptions. The program also covers other benefits like dental, hearing aids, and long-term care. It also offers day programs and other on-site programs such as meals. There are no cost-sharing or copayment requirements, and the program is offered to residents of Wards 7 and 8.

[17] District of Columbia, Department of Healthcare Finance. District Dual Choice (D-SNPs). https://dhcf.dc.gov/page/district-dual-choice-d-snps

Highly Integrated Dual Eligible Special Needs Plan

Under the Dual Choice program, a "HIDE SNP" is responsible for covering and managing almost all Medicare and Medicaid benefits for enrollees. All medical care is covered, including doctor visits, hospital care, and prescriptions. As of 2022, this includes LTSS, including EPD Waiver services. There is no cost-sharing or copays for individuals enrolled in Medicaid, but fees may apply for those with more limited coverage (e.g., Qualified Medicare Beneficiaries).

Impact of the COVID-19 Pandemic on Long-Term Care

Given the unanticipated costs associated with COVID-19 protocols and procedures, the District, along with other states, evaluated options and adopted new measures to keep patients healthy and safe. COVID-19 pandemic Medicaid enhanced rates were temporarily applied by DHCF effective March 2020 to support long-term care providers in managing the increased costs due to screening, personal protective equipment, cleaning, sanitation, and other operational costs required to comply with coronavirus guidelines during the public health emergency. DHCF plans to maintain the enhanced rates at least through the federal public health emergency.[18] DHCF implemented rate increases above the established Medicaid rates of 15 percent for assisted living facilities and 20 percent for nursing facilities beginning in March 2020. In addition, DHCF implemented enhanced rates for home health agencies of 50-125 percent, reimbursing for home health overtime or increased pay for aides working with COVID-19 positive or -exposed Medicaid beneficiaries. During the COVID-19 pandemic, there was an increased need for home health aides and in-home support services due to decreased or delayed utilization of preventative and chronic care.[19]

The home/patient-centered systems that were created could be expanded to reinforce aging in place. This includes but is not limited to in-home visits from an assigned facility, family support programs, and collaboration with local and community stakeholders to provide services and supports within proximity. Accessibility to these services and supports should also be considered per the COVID-19 Pandemic Health and Healthcare Recovery Report. One of the recommendations that would support home/patient-centered care is “expanding administration of services for Medicaid-eligible populations through telehealth, assisted telehealth or home-based models,” which would minimize the need to visit facilities and prolong the management of care to the community.

[18] District of Columbia, Department of Health Care Finance. Transmittal 20-17 Temporary Enhanced Reimbursement Rates for District Nursing Homes Due to COVID-19. https://dhcf.dc.gov/publication/transmittal-20-17-temporary-enhanced-reimbursement-rates-district-nursing-homes-due

[19] District of Columbia, Department of Health. (2021, May 28). COVID 19 Pandemic Health and Healthcare Recovery Report. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Pandemic-Recovery-Report_May-2021.pdf

The long-term complications of COVID-19 remain unknown. However, post-COVID-19 complications persisting more than a month, or "Long COVID", has also increased the need for long-term care facilities, especially for individuals with pre-existing chronic conditions. Emerging data suggests that a COVID-19 infection could cause long-term respiratory, cardiac, and neurological complications, which will warrant the expansion of long-term care facilities and services. Along with physiological complications of COVID-19, psychological complications such as perceived social isolation have necessitated a focus on social needs.[20] A concerted effort that incorporates health equity would holistically meet the community's needs and prevent saturation of long-term care facilities with the anticipated increase in demographic compounded with the long-term effects of the pandemic.

[20] Lopez-Leon, S., Wegman-Ostrosky, T., Perelman, C. et al. More than 50 long-term effects of COVID-19: a systematic review and meta-analysis. Sci Rep 11, 16144 (2021). https://doi.org/10.1038/s41598-021-95565-8

Future Needs for Long-Term Care in the District

Due to the chronic disease burden of the aging population, an increasing number of older individuals will require long-term care and supports. According to the Administration on Aging, an individual 65 or older has a 70 percent chance of requiring long-term care. This need could be due to conditions that are physical, mental, or emotional. The inability to perform daily tasks successfully can potentially lead to a decline in quality of life.

According to the State Data Center Forecast Summary, the 65 and older population in the District of Columbia is projected to grow an average of 1.1 percent between 2020 and 2025. The average growth rate is projected to decline between 2025 and 2030 to 0.6 percent, indicating that by 2030, 10.8 percent of the total DC population will be age 65 or over[21] (Figure 6).

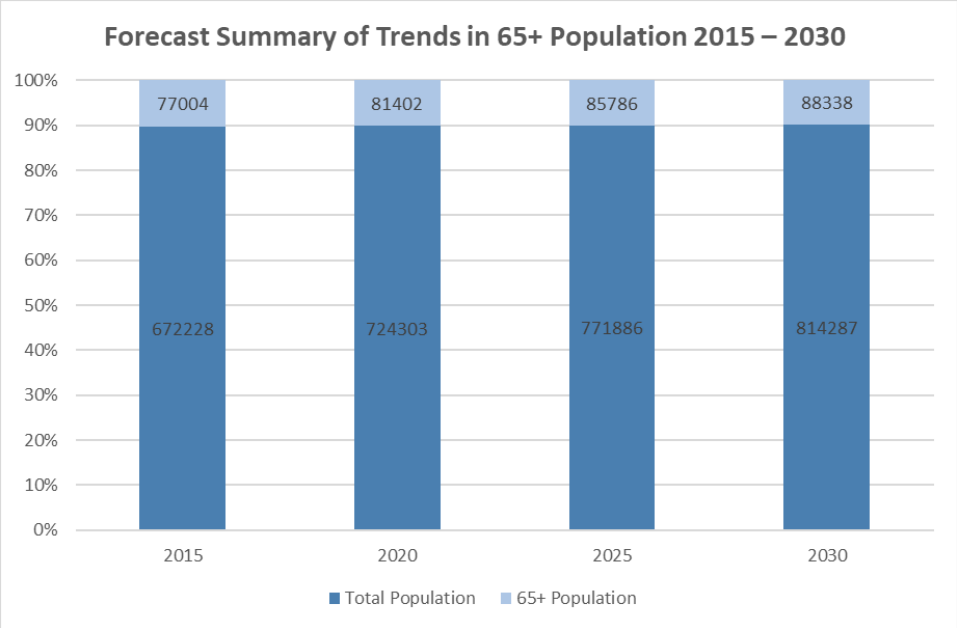

Figure 6

Data collected by the Kaiser Family Foundation reports 26 percent of the District's Medicaid enrollees are categorized as elderly and disabled.22 However, this population

[21] District of Columbia State Data Center, Population Forecast Summary.
[22] Henry J Kaiser Family Foundation, Medicaid in the District of Columbia.

accounts for 59 percent of the expenditures. In addition, a cost of care study performed by GenWorth determined that with a 3 percent annual inflation rate, and the District projects the daily median cost to be $519 for a semi-private room at a nursing home and $577 for a private room by 2030 compared to the current expenses of $386 and $429, respectively.[23] Any future effort to decrease spending and promote independence and aging in place will depend on more Medicaid beds in community-based facilities such as assisted living facilities and community residence facilities. Currently, the majority of beds are private-pay only. There will also be a need to continue existing long-term support services. DC Health can accomplish this through collaboration with sister agencies to streamline programs and support interface. Some of the services planned and needed are described below.

D-SNP Expansion

In 2022, the District expanded its existing D-SNP program into a more comprehensive program that integrates Medicare and Medicaid benefits into a single program. That means that there will be one set of comprehensive benefits and one accountable entity to coordinate the delivery of services to help coordinate the unique needs of individuals. This will further simplify health care for participants and promote greater care coordination.

The Aging Population

The District must prepare for the aging of Generation X by 2030 and the Millennials by 2050. There will not be rapid growth to 2030, however, there will be more rapid growth of the elderly population with the aging of the Millennials. There may be demands for specific services that reflect the values of those generations.

The District of Columbia's State Plan for Aging provides direction for DACL's administration and coordination of services. The plan was developed to represent federal expectations and the District's priorities.[24] There are four goals to accomplish the future commitment to the elderly population:

[23] GenWorth (2021) Cost of Care Survey. https://www.genworth.com/aging-and-you/finances/cost-of-care.html
[24] District of Columbia, Office on Aging, District of Columbia State Plan on Aging.

Goal 1: Strengthen Programs, Service Coordination and Quality of Services

Goal 2: Improve Access to Community Services and Supports in the District and Ensure the Agency is Driven by Customer Service Experience

Goal 3: Promote Living Well in the District

Goal 4: Empower the Aging Workforce

When preparing for the aging of future generations, consideration for expansion and development of resources and programs are necessary to accommodate those generations and their values. Increases in funding for agencies providing long-term care social and wellness programs, and inclusion of telehealth in Medicaid benefits and budgeting – which includes ensuring digital capacity within the home settings – are critical to anticipate the future needs of the District's elderly population.

Additionally, it is critical that the District continue to support programs that reinforce aging in place. Utilizing the family unit to aide in long-term care when appropriate, is ideal for most persons in need of supportive care, as well as promoting senior wellness programs in the community. Conversely, there is an ongoing need to develop assisted living facilities and other housing opportunities in home and community-based settings that accept Medicaid and private insurance plans as appropriate.

CURRENT CHALLENGES

In recent years the District like other states have a significant presence of homeless persons that are aged 55 years and older.[25] Hospitalization of the homeless population and discharge planning has sprouted a new host of challenges for a person with no fixed address. In instances where the discharge plan requires continued non-acute medical intervention for a person with behavioral challenges a skilled or nursing home level of care becomes a difficult placement option. Discharge planning aims to effectively transition a patient's care from the hospital to the community, addressing the interdisciplinary care needs for a patient's recovery.[26] Typically, skilled and nursing

[25] https://www.axios.com/local/washington-dc/2022/05/19/dc-aging-homeless-issues

[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7435079/

facility levels of care are not structurally equipped to provide mental health interventions e.g., psychiatric and related modality supports on a daily basis. As a result, hospitals are experiencing longer in-patient days for patients that individualized mental health care and services are not a typical fit in the typical long-term care skilled and nursing home setting.

Workforce

Future needs will require more workers to provide personal care services. At this time, other than the family or direct hire by the beneficiary (DHCF Services My Way), the provider must be a licensed home health aide. Although the District has approximately 8,000 licensed home health aides, there is currently a shortage in the workforce for personal care services. In order to retain these workers, an increase in minimum pay would be required. Perhaps, a study on the utilization, work hours, and pay for home health aides would better inform any legislative requirements.

CONCLUSION

The passage of the Study of the Long-Term Care Facilities and Long-Term Care Services Act of 2018 by the Council of the District of Columbia on December 4, 2018 was the impetus for this report. Information gathering for this report included virtual meetings held with several District agencies, DC Health Care Association, and the Long-Term Care Ombudsman. Literature reviews were conducted, and data was gathered from DC Health Care Finance and DC Health. A survey was administered to the skilled and nursing facility providers to capture the types of services provided, bed capacity, and types of insurances accepted at each facility.

In part, the need for this study came from recent closures of skilled nursing facilities (SNF) and the overall decrease of 439 nursing home beds over the previous decade. However, the number of licensed assisted living residences (ALRs) have increased in number to 13 facilities in 2021 for a total of 950 beds. Taken together, the total number of licensed skilled and nursing facility beds in the District was 2,447 at the end of Fiscal Year 2021 (September 30, 2021). During that time there were also District residents residing in Maryland SNFs, though none in Virginia SNFs, contracted by DC Health Care Finance that were not included in the District facility bed count.

Beyond bed capacity, there are additional challenges in paying for nursing home services that the Act was designed to explore. The payment for skilled and nursing facility care is multifaceted and can include private pay, Medicare, Medicaid, long-term care insurance, and other insurance types. The payment for ALRs is particularly challenging as it is predominately private pay with only 5 facilities having contracts with DC Health Care Finance for Medicaid beneficiaries and that funding is limited to specific services. Payments for long term care services can be complex and vary depending on the individual's financial and insurance profile.

In addition to workforce stressors from the COVID-19 pandemic, the District also experiences the ongoing national workforce shortage in the health care industry and nursing in particular. The need to incentivize District residents to enter and stay in jobs in long-term care is not a new phenomenon. But the pre-COVID-19 pandemic staffing challenges have only been exacerbated by the pandemic's impact on burnout and retention.

Some methods that are being pursued by the DC Health Care Finance include conducting a minimum pay rate study for certain long-term care workers. Future needs will require more licensed home health aides to provide personal care services. Creative strategies can be explored to retain existing workers and to attract new workers to the health care field. Perhaps, a study on the utilization, work hours, in addition to pay for home health aides would better inform us of workplace barriers.

DC Health has begun identifying and implementing solutions to address healthcare workforce shortages. The recent expansion of the Health Professional Loan Repayment Program to include part-time participants, private sites, and new subspecialities is another strategy to enhance the medical, dental, nursing, and social workforce. Previously the program provided loan repayment assistance to full-time primary medical (Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, and Certified Nurse Midwives), dental (Dentist and Registered Dental Hygienists), mental health (Licensed Clinical Social Workers, Clinical Psychologists, Nurse Practitioners, and Licensed Professional Counselors) providers, only at non-profit or public sites. The Program also included medical specialist (Psychiatry and Obstetrics/Gynecology) providers who practice in Wards 7 or 8. Looking further upstream, DC Health is creating a scholarship for prospective health professionals and collaborating with schools to improve and expand training programs. DC Health's new scholarship program, the High Needs Scholarship Program, to attract and train entry level health care workers such as home health aides, certified nursing assistants, and emergency medical technicians.

Finally, changes in population will have a significant impact on availability of services. Although the growth rate for the elderly population is predicted to be slower than in past decades and there is a growing desire by some members of the community to have available services that will allow for aging in place, some individuals, however, will still need or want to move into an assisted living residence, which would be more cost effective than a nursing facility. In order to meet that need, there must be more assisted living residences and other community-based facilities in the District that accept Medicaid as a payment source. Assisted living may also be beneficial to some residents to receive the required support and services if Medicaid beds are unavailable.

Looking forward, as the population ages, technology and the availability of telehealth services will continue to evolve and impact the provision of long-term care services and support. With the expectation of the Millennial generation aging into long-term care and support services by 2050, it is critical for the District to ensure telehealth be expanded to accommodate this larger elderly population.

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