

**Testimony Submitted to the Committee on Health Services**

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For the District of Columbia**

**Department of Health  
Medical Assistance Administration  
&  
Health Regulations Administration**

**Performance Oversight Hearing  
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Good Day, Councilmember Catania and Members of the Committee on Health Services. I am Jerry Kasunic, the D.C. Long-Term Care Ombudsman, and I represent the approximately 5121 residents of licensed nursing facilities and community residence facilities in the District. I thank you on their behalf, and on the behalf of their families and friends, for permitting me to come before you today to present their concerns and those of my staff in the D.C. Long-Term Care Ombudsman Program.

As you are aware, the Long-Term Care Ombudsman Program is part of the D.C. Office on Aging Senior Service Network and is charged by Federal and D.C. Law with representing the interests of some of the District's most vulnerable citizens – residents of long-term care facilities -- whose physical and mental disabilities make it impossible for them to advocate effectively for themselves.

The D.C. Long-Term Care Ombudsman Program (Ombudsman Program) continues to appreciate your concentrated focus and hard work to ensure the health care system improves and is held accountable to deliver quality of care.

The Ombudsman Program will focus on several areas of importance pertaining to the Department of Health's Medical Assistance Administration office (MAA) and the Health Regulation Administration (HRA). But first, the Ombudsman Program would like to commend the efforts of both the MAA and IMA staff for their hard work to ensure D.C.'s elderly were receiving medication and medical assistance last year when the Deficit Reduction Act was introduced, which changed the Medicaid eligibility procedures.

The Ombudsman Program has compiled several MAA and HRA topic areas and will be submitting comments pertaining to the following:

MAA:

1. The Aging and Disabled Resource Center (single point of entry),
2. Medicaid Case Mix Reimbursement system,

3. Personal Needs Allowance; and,
4. Medicaid Support for Mental Health Residents.

HRA:

1. Quality of Care Statistics,
2. Lack of Enforcement,
3. Alternative Programs and Collaborative Efforts; and
4. Assisted Living

A number of our topic areas have been brought to this Committee's attention in the past, and addressed by the Long-Term Care Taskforce, but bare repeating, rethinking and retooling.

**Medical Assistance Administration:**

The Medical Assistance Administration is managing the Aging and Disability Resource Center (ADRC) inside the Department of Health. The ADRC's main mission is to provide assistance D.C. residents seeking long-term care and health delivery options within their community and to be a one-stop shop for seniors seeking information and social services. However, the Ombudsman Program is unaware of the progress that MAA has made to contract with a community provider in order to create a fluid single point of entry system. If the decision is keep the ADCR within any MAA structure, the Ombudsman Program would like for this Committee to seek answers to the following questions:

- a. Has MAA advertised to the general public that ADRC has changed locations, and have email addresses and phone numbers been widely advertised?
- b. Does MAA have the proper staff in place to handle multiple calls and refer D.C. residents accordingly within a timely fashion (within a 24 hour period)?

- c. Will MAA need additional personnel or resources to maintain and expand services into the community (such as providing case management assistance when required)?

Over the past several months, the Ombudsman Program has asked these questions but has not received adequate responses. If MAA is planning to outsource the ADCR, when can the community expect this happen and will there be a public announcement in order to ensure the new contact information is well advertised?

As reported last year, the Ombudsman Program continues to recommend to MAA that the Medicaid Case Mix Reimbursement (Case Mix) system, the new nursing home Medicaid reimbursement methodology, should have an external review of the implementation and effectiveness of the program. The Ombudsman Program continues to seek a study or oversight mechanism to ensure that MAA is being responsible with taxpayer's money as well as ensuring the highest quality of care to all nursing home residents.

Because Medicaid reimbursement issues are a point of debate, it is the understanding of the Ombudsman Program that MAA is re-introducing Medicaid eligibility amendments for potential and current Medicaid beneficiaries by changing the 1728 Medicaid Eligibility Review form. MAA appears to be proposing a Medicaid eligibility change from a functional application model to a clinical model. MAA, advocates and several providers years ago met and agreed that the clinical model would not work if our citizens needed a waiver to be transferred from the nursing home into the community. Thus, the functional model was favored over the clinical model to make transitioning easier for long-term care residents. In light of the last meeting with MAA, the Ombudsman Program strongly suggests that a pilot study be conducted and publicly debated prior to changing the eligibility requirements that will affect thousands of D.C. residents.

Personal Needs Allowances have been increased for community residence facilities, and assisted living residents, however, the nursing home population has not

received an increase in over a decade. Because of the accelerated rate of the cost of living in the District of Columbia, several nursing home residents comment that they cannot afford using public transportation for medical appointments, seeing family members, or even purchasing personal items on \$70.00 a month. The Ombudsman Program is suggesting that MAA discuss and implement increasing the Personal Needs Allowance (PNA) with the Director of Health, the officials from the Central Referral Bureau and with the city council in order to increase and match the PNA that residents are receiving within the community, which is \$100.00 a month.

The Ombudsman Program has reported in the past the severe problems facing long-term care residents who are seeking mental health services within a nursing home or when being transferred to a community dwelling. Over the past several years, the Ombudsman Program has participated with government officials from the Department of Mental Health (DMH), DOH, Health Regulations Administration (HRA) and MAA; Income Maintenance Administration (IMA), DCHCA, CRB, and the Long-Term Care Taskforce members to create and implement a simplified process for enrolling mentally ill residents into the Medicaid program in order to receive services in long-term care facilities. Due to the convoluted and highly bureaucratic system that currently exists, little information or services are shared between the long-term care providers and DMH. Furthermore, the current Medicaid system is not sufficiently progressive in linking long-term care and community services for residents.

The Ombudsman Program strongly encourages MAA to work with DMH, APRA (Addiction Prevention and Rehabilitation Administration), DCHCA (D.C. Health Care Association), resident councils and advocates to create and implement policies to ensure that D.C. residents are receiving mental health services and are able to direct those services when leaving long-term care facilities.

**Health Regulations Administration:**

The Ombudsman Program continues to have several major concerns regarding how the survey team enforces both the local and federal nursing home regulations, and

how the Health Regulations Administration (HRA) protects residents. During the past year, the Ombudsman Program staff—including myself—had tracked breaches of confidentiality when reporting complaints to HRA staff. It appears that HRA staff has a very comfortable relationship with the long-term care providers and has no problems handing over complaint information instead of properly investigating the matter and formulating a report regarding the allegations that are made from this Office. For example, this ombudsman was recently contacted by a nursing home administrator (via voice message) and was told that DOH officials called her stating that I complained to DOH, HRA and repeated (verbatim) the information that was given by the Ombudsman Program. Not only are their stringent confidentiality requirements between the Ombudsman Program and long-term care residents, but between our Program and HRA as well. Furthermore, when our complaints are given directly to the Provider without HRA conducting a proper and separate investigation, the Ombudsman Program, resident and the resident's family are put in a compromising position. **THIS PRACTICE MUST STOP.**

During fiscal year 2006, the Ombudsman Program has tracked the number of complaints coming from DOH, HRA licensed facilities (nursing home and community residential facilities); we have experienced the following activities from 24 CRFs and 20 Nursing Homes:

Number of Cases: 541

Number of Complaints: 1808

Verified Cases: 538 (99%)

Verified Complaints: 1784 (98%)

Average Days for Closure per Case: 18

Number of Complaints Partially or Fully Resolved: 1644 (91%)

Number of Complaints Referred to Outside Agency: 96 (5.3%)

Number of Complaints Withdrawn or No Action: 57 (3.2%)

(The Ombudsman Program has experienced an increase of 160 complaints over last year)

The four most frequently reported complaints of all DOH licensed facilities were:

1. Quality of Care (29%)
2. Lack of staffing or un-responsive staff (22%)
3. Autonomy, Choice, and Exercise of Rights (16%)
4. Environment (13%)

According to DOH, HRA's website, there are no current notices of infractions levied against any nursing home or community residential facility for FY 06, or to this current date.<sup>1</sup> However, according to the DOH enforcement webpage, the federal government has levied \$108,901.00 against five nursing homes for nursing home infractions that affect quality of care and life for residents.<sup>2</sup>

According to the discussions that the Ombudsman Program has had with the Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS), Civil Monetary Penalty (CMP) monies have been collected from the fines that are listed above. *CMS states that CMP funds that are sent to each state are based on the nursing home total nursing home Medicaid population. Thus, if the District of Columbia has 82.3% of its nursing home population participating in the Medicaid program, 82.3% of the fines collected by the federal surveyors, listed above, should be returned by CMS to DOH in order to fund best practices, alternative programs, assist residents during facility closures and when personal items are either lost or stolen.* The Ombudsman Program is seeking information of how these funds have been used ever since CMS introduced the CMP program back in 1996.<sup>3</sup> In addition, the Ombudsman Program will be researching whether DOH has received FY 06 funds and how they have been used to date, since we have advocated strongly that CMP funds be used for government-supported alternative nursing home programs. The Ombudsman Program will continue its investigation and

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<sup>1</sup> The DOH, HRA website was visited throughout the year by the Ombudsman Program in order to review the types of citations and monetary fines levied, however, as of 2/27/07 there has been no public reporting of any type nursing home or community residential facility infraction. See attachment labeled No. 1.

<sup>2</sup> See attachment No. 2.

<sup>3</sup> CMS has provided a CMP accounting that reports **D.C. has received \$547,112.25 in CMP federal funds** since 1996. The Ombudsman Program will be seeking a meeting with DOH to learn how the monies have been used.

tracking of federally collected citations (CMP funds) and how this money has been used and for what purpose.

It has been refreshing to work with Dr. Feseha Woldu, Deputy Director, Health Professional Licensing and Regulation Administrator, Department of Health, who appears to be focused on creating assisted living regulatory protocols. In addition, the Ombudsman Program is seeking Dr. Woldu's leadership and managerial skills to assist in the development of nursing home alternative programs, since he is very knowledgeable about how to measure quality of care within the regulatory field. We hope to strengthen our collaborative efforts with his office.

However, it has been approximately seven years since the passage of the D.C. Assisted Living Regulatory Act of 2000. Because of the DOH's delay in the creation and implementation of the Act, the Ombudsman Program plans to address two significant issues: DOH assisted living licensure protocols and Medicaid waivers.

In these seven years, the DOH has yet to issue its first assisted living license, although there are assisted living facilities in operation. The Ombudsman Program has received increasing numbers of complaints regarding assisted living services and contracts. One additional concern that arises of the lack of licensure enforcement is the District of Columbia's vulnerability to corporations which may take advantage of our elder population due to the lack of sufficient monitoring, oversight, and licensure standards. For example: Family members feel compelled to hire private duty nurses due to the fact that assisted living facilities are unable to treat their loved ones with the current staff on duty. There are two Ombudsman Program concerns regarding this issue: 1) the lack of regulatory oversight to review the level of acuity need of a resident, and 2) are assisted living facilities actually providing the care that they advertise and promise within an admission contract? Without oversight enforcement and a definition of what an assisted living facility services is, the District may be vulnerable to legal action. Further, the quality of care of these residents may be in jeopardy.

The District remains fortunate that to date there have not been any deaths or serious accidents that can be attributed to the lack of oversight of DOH, HRA of these facilities.

As a direct result of the lack of implementation of the Assisted Living Regulatory Act of 2000, when the DOH implements the Elder and Physical Disability Waiver, which includes Consumer Directed Care and Assisted Living Services assistance, residents of the District of Columbia may find that they cannot utilize the waiver since no oversight agency has the responsibility to ensure services are being delivered. Without the oversight agency, the District may be in conflict with federal Medicaid and health care regulatory standards.

The Ombudsman Program requests that this Act be implemented and that appropriate licensure protocols be put in place immediately.

Even though the Ombudsman Program has several HRA and assisted living regulatory concerns, we will be meeting with Dr. Woldu and his staff in order to strengthen both the Ombudsman Program and HRA's relationship to move projects forward that improve the quality of care and life for residents of licensed DOH facilities.

I thank you for letting me come before you today and giving testimony of the Ombudsman Program's concerns, and look forward to answering any questions this Committee may have regarding this testimony.