High Medical Costs and Homelessness Vulnerability Among Older Adults in Washington, DC: *A Policy Analysis*

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ABSTRACT

The increasing risk of homelessness among older adults in Washington, DC, fueled predominantly by soaring medical expenses, represents a pressing societal concern. Despite notable reductions in overall homelessness rates, the number of older adults experiencing homelessness remains unchanged. As the demographic of older adults grows, the urgency to address this issue escalates. This article examines the complex nexus of high medical costs, poverty, and homelessness among the elderly community in Washington, DC. The article proposes, evaluates, and recommends five policy alternatives geared toward addressing this multifaceted predicament. After employing a rigorous policy analysis approach, alternative two, which focuses on expanding Medicare coverage by lowering eligibility criteria from 65 to 63 years of age, is the recommended policy choice. This proposed recommendation not only aims to ameliorate immediate financial vulnerabilities but also endeavors to democratize access to indispensable healthcare services. Through a blend of empirical analyses, this measure best mitigates the risk of homelessness among the elderly populace in the nation's capital. In synthesizing empirical insights, theoretical perspectives, and policy pragmatism, this article seeks to catalyze informed dialogue and efficacious action toward safeguarding the dignity and security of older adults in Washington, DC, and beyond.

https://doi.org/10.4079/pp.v31i0.8

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ACKNOWLEDGEMENTS

The author would like to extend her gratitude and appreciation to her Associate Editor, Carolina Gutierrez, and Faculty Reviewer, Professor Michael Worth, for their thoughtful and constructive feedback during the editorial process. The author is grateful to Editor-in-Chief Frank Bewkes and Managing Editor Sarah Mohammadi for their valuable insights and continued support. She also thanks Professor Eiko Strader for her guidance in the original writing of this paper. Finally, a heartfelt thank you to her husband, Chinmay Joshi, for being her pillar of strength and for providing his critical feedback on the paper. She also thanks her wonderful family for their endless love, unwavering support, and encouragement throughout her graduate studies and continued academic journey.

There is a deep concern about the growing risk of homelessness among older adults in Washington, DC. As of July 2023, the US Census Bureau listed on its website that roughly 13 percent of residents in the nation's capital are older adults (US Census Bureau 2023a). The risk of persons over 65 years becoming homeless increases more than twofold compared to their younger counterparts, and this is a particularly pressing issue in Washington, DC. According to the 2022 Point in Time (PIT) count, the annual census of individuals experiencing homelessness suggests that the overall number of people experiencing homelessness in the District of Columbia has declined by 13.7 percent over the past year (PIT Report 2022, Figure 6, 27) and decreased by 47 percent from 2016 (Executive Office of the Mayor 2022a).

Moreover, national demographic trends indicate a significant surge in the population of individuals aged 65 or older, which is attributed to the baby boomer generation reaching retirement age. This trend underscores the pressing need to address the homelessness issue within this expanding demographic. In 2017, there were more than 40,000 people over the age of 65 experiencing homelessness in the US. By 2030, that number is expected to increase to more than 106,000 (PIT Report 2022, 26). This pattern is primarily attributed to high medical costs across the US. The 2022 KFF Health Care Debt Survey indicates that 22% of older adults face medical debt (Lopes et al. 2022, Fig 2). In addition to the affordable housing crisis, geriatric medical issues, such as cognitive decline and long-term care needs, fuel the growth of elder homelessness. Furthermore, older adults who experience homelessness face unique vulnerabilities due to health or mobility limitations. They may also have more significant health concerns not typically seen in homeless service systems, such as Alzheimer's disease or cancer (PIT Report 2018, 20). With fixed incomes and limited savings, growing medical and nursing home costs add to the already substantial risk of homelessness among older adults. Additionally, per the US Census Bureau's American Community, 13.9 percent of people aged 65 and above live below the federal poverty level, making them even more vulnerable to unstable housing (DC Health Matters 2023). Hence, it is important to recognize and address these issues to consider policies that target the elderly homeless by prioritizing their medical needs. It is imperative that we prevent these vulnerable individuals from facing the difficult choice between covering their medical expenses and maintaining a financially stable household.

Amidst the backdrop of escalating medical costs and the pressing issue of homelessness among older adults, there emerges a solution: Medicare, a federal health insurance program curated specifically for people 65 or older. This healthcare initiative stands as a potential solution to alleviate the burden of medical debt among older adults, offering a glimmer of relief amidst their plights.

To fully comprehend the significance of this concept, it is crucial to distinguish Medicare from Medicaid, another vital health coverage initiative. Medicaid plays a pivotal role as a safety net for low-income individuals, offering essential healthcare support to various

demographics, including seniors. However, a noteworthy nuance lies in the fact that not all seniors qualify for Medicaid due to income restrictions. Considering this critical distinction, this paper advocates for an innovative strategy to reduce the age eligibility for Medicare from 65 to 63. This proposed adjustment is not merely an isolated initiative but a complementary measure to Medicaid. While this proposal would extend the reach of Medicare nationwide, the focus of this analysis is on the effect and feasibility of reaching a broader demographic of seniors in Washington, DC. This is particularly pertinent for those who, despite earning income, may fall outside the income criteria for Medicaid.

Thus, this proactive measure of reducing the age requirement in Medicare ensures more inclusive access to essential healthcare services by addressing the financial vulnerabilities of older adults on fixed incomes and with limited savings. In essence, this bold step is a structured approach that recognizes the complex financial landscape of older adults, striving to bridge gaps in healthcare coverage. By mitigating the risk of medical debt, especially for those who may not qualify for Medicaid, this proposal stands as a preventive measure against the looming threat of homelessness among Washington, DC's elderly population.
While this age adjustment addresses the needs of Washington, DC's older adults, it holds implications beyond the confines of the capital. As Medicare is a federal program, such a change would indeed have a nationwide impact and potentially benefit seniors across the country facing similar financial challenges. However, for this paper, the focus remains squarely on the specific impact within Washington, DC.

This paper begins by addressing the critical concern of older adults in Washington, DC: the imminent risk of homelessness, often exacerbated by the burden of soaring medical costs that push them into poverty. The first section delves into the multifaceted challenges faced by elderly individuals, analyzing the intersection of high medical expenses and poverty as significant contributors to the looming threat of homelessness. Following the exploration of the problem, the article proceeds to introduce and analyze five policy alternatives. Each proposed strategy is carefully crafted to address the root causes and mitigate the risk of homelessness among older adults in Washington, DC. Next, this paper will conduct a comprehensive evaluation of each policy alternative. Evaluative criteria are systematically applied to each alternative to assess the potential effectiveness, cost, administrative feasibility, and political feasibility of the proposed solutions. This analytical approach aims to provide a nuanced understanding of the strengths and weaknesses inherent in each policy option. The article then assigns weighted values to the identified criteria to ensure a nuanced and balanced assessment, considering the varying degrees of impact and feasibility associated with each criterion. To conclude, the cumulative insights gathered from the evaluations and weighted assessments guide the formulation of a well-informed and substantiated final policy recommendation. This recommendation aims to strategically and effectively mitigate the risk of homelessness stemming from elevated medical expenses among adults in Washington, DC.

POLICY PROBLEM

The average life expectancy of a person experiencing homelessness is estimated between 42 and 52 years, compared to 78 years in the general US population (PIT 2022, 26). The 2022 Point in Time (PIT) enumeration resulted in a total count of 7,605 individuals experiencing homelessness in Washington, DC (PIT 2022, 2). This number further increased by 18 percent from 2022 to 2023. As per the 2023 PIT Report, a total of 8,944 people experienced homelessness (PIT 2023, 10). In Washington, DC, homelessness serves as a striking illustration of these alarming statistics, given that the average life expectancy for residents in the district is nearly 20 years lower than the national average (PIT 2023, 26). This contrast is notable, considering that Washington, DC, is one of the most affluent cities in the United States, with a median household income of $101,722 (Census 2022).

Moreover, the city faces an increasingly challenging battle against homelessness, exacerbated by the aging demographic of the homeless population, which introduces a new array of difficulties. Given the city's aim to eliminate homelessness by 2025, the need to focus on the issue of elderly homelessness requires immediate action (Cirruzzo 2021).

According to a report by the Office of the Budget Director Council of the District of Columbia, the population of older adults in DC amounted to approximately 83,600 in 2019, and this figure is projected to increase by up to 24.4 percent by 2030 (Office of the Budget Director 2020, 1). The senior demographic in the district is experiencing substantial growth. From 2007 to 2017, there was a notable 13.5 percent increase in the number of older adults. This trend is expected to persist in the coming years as the baby boomer generation continues to age. Over the next five years, approximately 44,200 baby boomers in DC will turn 65 years old (2). As the population ages, the number of elderly individuals experiencing homelessness is likely to increase.

Homelessness impacts individuals and families of all ages; however, it is particularly concerning when it impacts older adults as they face distinct challenges related to their age and health conditions. Homeless seniors experience more complex health needs than those with stable housing. A noteworthy 66 percent of senior citizens in the nation's capital grapple with at least one chronic condition, while 25.9 percent have a disability (8), leading to an increase in healthcare expenses and restricted employment opportunities. With only 23 percent of seniors employed (17), their reliance on a fixed or limited income exacerbates the challenge of covering unexpected expenses, which can pose difficulties in managing medical bills. Furthermore, 74.1 percent of older adults live alone, increasing the likelihood of experiencing social isolation (11).

The statistic that 74.1 percent of older adults live alone underscores a significant societal trend that has profound implications for their well-being. Living alone not only increases the likelihood of experiencing social isolation but also amplifies the risk of loneliness.

This state of loneliness has far-reaching consequences, extending beyond mere emotional distress. Studies have established a direct link between loneliness and a myriad of medical conditions, including high blood pressure, heart disease, obesity, weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even mortality (11). Moreover, the correlation between medical conditions and high healthcare expenses cannot be overlooked. The burden of medical bills can quickly escalate, particularly for older adults who are already living alone and may have limited financial resources.

For older adults already grappling with the challenges of living alone and the associated risks of loneliness-induced medical conditions, the added strain of overwhelming medical debt poses a dire threat. Accumulating medical debt can swiftly spiral out of control, pushing elders to the brink of financial instability or, in severe cases, bankruptcy. The confluence of these factors creates a precarious situation, leaving vulnerable elders teetering on the edge of homelessness. As medical bills pile up and financial resources dwindle, the prospect of losing stable housing becomes increasingly imminent.

The susceptibility of older individuals to homelessness due to the burden of medical debts, loneliness, and poverty emphasizes the importance of addressing their specific needs and requirements. Access to ongoing medical care is important to mitigate the risk of homelessness among seniors, as it ensures that they do not accrue unmanageable medical bills that can lead to financial instability. Consistent medical care not only addresses immediate health concerns but also helps prevent the escalation of medical conditions that may require costly interventions in the future. Through regular check-ups, screenings, and preventive measures, seniors can better manage chronic illnesses and maintain their overall health. By addressing health issues in their early stages, medical interventions can often be less invasive and less costly than if left untreated. Furthermore, consistent medical care allows healthcare providers to monitor and manage chronic conditions effectively, reducing the need for emergency room visits or hospitalizations. This proactive approach improves health outcomes and helps mitigate the financial burden associated with costly medical emergencies.

Therefore, the implementation of policies aimed at improving healthcare access for seniors is crucial. By ensuring that older adults have consistent access to necessary medical care, we can help prevent excessive medical bills leading to debt and reduce the risk of homelessness. Investing in preventive healthcare measures will improve the quality of life for older adults and contribute to the overall well-being and stability of our communities.

POLICY ALTERNATIVES

As the elderly population in DC continues to expand, the challenges associated with reducing high medical costs leading to poverty and heightened risks of homelessness must be addressed. With the goal of tackling these issues, this article proposes, analyzes, and discusses four policy alternatives along with the current strategy or status quo in place in DC

to deal with the issue at hand. Each of these alternatives has been formulated with careful consideration of the various stakeholders affected by the policies, including older adults, caregivers, and government agencies.

1. STATUS QUO

DC's current strategy to address homelessness is primarily focused on providing emergency shelters and subsidized housing, and it falls short of effectively addressing the complex challenge of homelessness intertwined with high medical costs (Burt and Hall 2008, 1). Based on the latest trends, the risk of medical bankruptcy is likely to remain. The current policies around investment in digital health technology through telemedicine may not be fully meeting the needs of the aging population in DC (Neufeld and Doarn 2015, 1). In a report by the DC Department of Health, the abrupt shift to telehealth during the pandemic illuminated a lack of uniformity in technological capabilities across health centers (DC Health 2021, 30).

Regarding the benefits caregivers receive for tending to elderly family members, caregivers in the District of Columbia collectively claim a total tax credit of $1,292 for their caregiving duties. (Mayblum 2023, 11). Furthermore, existing senior centers lack the capacity to accommodate the growing aging population. Unless better efforts are made, the current approach may continue to prove insufficient in addressing the challenges posed by the aging population in the district.

2. EXPAND MEDICARE COVERAGE BY LOWERING ELIGIBILITY CRITERIA FROM 65 TO 63 YEARS OF AGE

Alternative two proposes expanding Medicare coverage by reducing the eligibility criteria from 65 to 63 years of age to address the financial strain and diminish poverty among elderly people. A study by The University of Chicago Press Journal examined the effects of Medicare expansion on reducing medical debt and out-of-pocket healthcare spending among beneficiaries. According to the study, Medicare beneficiaries exhibited notably lower levels of medical debt compared to non-beneficiaries, resulting in a reduction of medical bankruptcy rates by more than 50 percent. The study also found that before Medicare enrollment, non-beneficiaries spent a significantly larger proportion of their income on healthcare costs compared to beneficiaries, however, after Medicare enrollment, this disparity decreased by 31 percent (Kyle and Goddeeris 2020). Expanding Medicare coverage, by lowering the eligibility criteria from 65 to 63[1] years of age can reduce medical costs and mitigate the threat of financial hardship.

This policy alternative aims to provide comprehensive medical coverage to more older adults, increasing their access to affordable healthcare and reducing out-of-pocket expenses. By expanding access to Medicare, 13,430[2] more older adults will benefit from reduced medical costs and achieve long-term financial stability.

3. INCREASE INVESTMENT IN DIGITAL HEALTH TECHNOLOGY THROUGH TELEMEDICINE

This alternative suggests investing more in telemedicine to improve healthcare access for the elderly. An article by the Center for Strategic and International Studies (CSIS) titled "Addressing an Aging Population through Digital Transformation," discusses the aging population and the need for digital transformation (Runde, Sandin, and Kohan 2021, 1). The proposed investment in digital health technology via telemedicine has the potential to relieve the financial strain of medical expenses and reduce the likelihood of poverty and homelessness. Telemedicine can be an attractive alternative as it enables remote access to healthcare services and reduces the need for physical visits to healthcare facilities, thus lowering medical costs. Overall, investing in digital healthcare solutions can help address healthcare needs and make the lives of seniors easier.

4. INCREASE CAREGIVER SUPPORT

Alternative 4 acknowledges the difficulties encountered by older adults in need of care and recognizes the pivotal role played by caregivers in providing such support. According to CSIS, digital solutions like wearable robotic devices and apps that track symptoms and medical appointments can help caregivers provide better support to older adults (Runde, Sandin, and Kohan 2021, 1). Most older adults, nearly 75 percent, rely solely on family and friends for informal care; the remainder depend on a combination of family care and paid help (Hendrickson 1988, 123). To bolster caregiver support, the implementation of comprehensive measures such as tax credits and caregiver training programs can significantly enhance the caregiving experience. Through these initiatives, caregivers can receive financial assistance and valuable skills to better fulfill their caregiving roles. Additionally, fostering community support networks and providing access to support groups can offer emotional and social support to caregivers, mitigating the risk of burnout. By empowering caregivers and equipping them with the necessary resources and support, seniors could potentially access more affordable and efficient care, leading to a reduction in overall medical expenses. Consequently, this could help alleviate the financial strains associated with caregiving costs and potentially decrease the risk of poverty and homelessness among older adults. This alternative is on the preventive side and focuses on providing more support to caregivers, which can help lift some of the financial burdens associated with caring for a loved one and reduce the risk of caregiver burnout (Hendrickson 1988, 126).

5. BUILD 8 ADDITIONAL SENIOR CENTERS IN DC

Alternative five proposes the construction of additional senior centers as a solution to lower medical costs, with the potential to reduce the risk of poverty and the likelihood of homelessness. According to a report by Harvard University's Joint Center for Housing Studies, seniors face multiple health issues and require ongoing care (Fernald 2014, 37). The

National Council on Aging estimates that approximately 1 million adults take advantage of the various health and wellness programs offered at nearly 11,400 senior centers. (Fernald 2014, 26). Senior centers offer essential support and social interaction that can improve the physical and emotional well-being of the elderly (Fernald 2014, 27). However, DC is currently facing a shortage of senior centers to accommodate its elderly population. With a population of 116,418 seniors age 60 and above, DC currently has only eight senior centers, meaning that there is only one senior center for every 14,552 adults (US Census Bureau 2023a). Even with a daily capacity of 40 individuals per senior center and the assumption that all seniors would want to make visits, each senior would only be able to attend the center once every four months. In order to address this shortfall, the article proposes that at least two senior facilities be established in each ward. This would require a total of 16 senior centers, ensuring that at least 50 percent of older adults in DC could visit the center at least once per month.[3]

Therefore, this alternative suggests building eight additional senior centers as a step towards providing adequate care and support for the elderly. The proposed alternative, rooted in preventive strategies, aims to empower seniors to proactively manage their health and well-being, thereby averting potentially costly medical expenses and ultimately reducing the risk of homelessness. By envisioning additional senior centers as dynamic community hubs strategically designed to complement the existing services, the impact on seniors' lives can be amplified. These enhanced centers not only provide engaging activities, daily group lunches, cutting-edge exercise equipment, and state-of-the-art computer labs to facilitate online medical bill filing, but they also foster a welcoming and supportive atmosphere conducive to holistic health. The critical link lies in the proactive engagement facilitated by these additional centers. Regular participation in health and wellness programs, coupled with the creation of a vibrant social environment, offers seniors consistent avenues to maintain and improve their health. This, in turn, will contribute to the reduction of medical bills by preventing or managing health issues at an early stage (Fernald 2014, 27). By expanding access to these preventative resources, seniors can actively address health concerns, mitigating the financial burden associated with extensive medical treatments. The establishment of eight additional senior centers is a strategic investment in the well-being of the elderly population, aligning with the broader goal of reducing the risk of homelessness by curbing the financial strain caused by high medical costs.

By promoting engagement and social connections, this policy alternative not only enhances the lives of seniors but also offers a practical solution to alleviate economic challenges linked to healthcare. This approach reinforces the resilience of our senior community in Washington, DC.

NAVIGATING PERSPECTIVES CRITIQUES AND CONSIDERATIONS OF PROPOSED POLICY ALTERNATIVES

While the proposed policy alternatives present promising and innovative approaches for

addressing the challenges confronted by older adults in Washington, DC, it is imperative to scrutinize potential critiques. Alternative two, expanding Medicare coverage, may elicit concerns about the strain on government budgets and the possibility of increased taxation, with critics questioning the long-term financial sustainability of such a policy shift. Similarly, individuals skeptical about the proposed surge in investment in digital health technology, as outlined in alternative three, may voice concerns about the significant financial commitments needed and the effectiveness of such technologies in addressing the varied healthcare requirements of the aging population.

The proposal to augment caregiver support in alternative four might face scrutiny over funding allocation, raising questions about the feasibility of sustaining comprehensive caregiver programs. Furthermore, alternative five, the proposition to build additional senior centers, could encounter opposition rooted in budget constraints and the necessity for significant infrastructure investment. It is crucial to recognize and navigate these critiques and engage in nuanced discussions that delve into the financial feasibility, long-term sustainability, and potential trade-offs associated with each alternative. Striking a balance between immediate concerns about high medical costs among seniors and the broader economic and societal implications of these proposed solutions requires a collaborative and inclusive approach. The multi-stakeholder nature of these alternatives underscores the need for a comprehensive dialogue that integrates varied perspectives, ensuring the formulation of policies that are not only effective but also sustainable for the aging population in Washington, DC.

EVALUATIVE CRITERIA

The formulation of the evaluative criteria to assess policy alternatives in tackling healthcare challenges for older adults in Washington, DC, was methodically shaped by drawing inspiration from the Bardach and Patashnik eightfold path, a framework for robust policy analysis (Bardach and Patashnik 2019). The eight stages of policy analysis include defining the problem, assembling evidence, constructing alternatives, selecting criteria, outlining projected outcomes, and finally confronting trade-offs. This eightfold path guided the strategic development of the criteria used, ensuring a systematic and thorough examination of each proposed alternative. This approach involved a meticulous adaptation of the eightfold path principles to the unique context of mitigating high medical costs and the consequential risk of homelessness among seniors in the capital.

The nuanced approach undertaken in crafting these criteria involved a multi-step process. This involved the identification of the key dimensions that are crucial for the success of policies in this context, such as effectiveness, cost, administrative feasibility, and political viability. Each dimension was then operationalized to create measurable and objective criteria for evaluation. Drawing on existing research, data, and expert opinions, the author refines the criteria to align closely with the specific challenges faced by older adults in Washington, DC. Moreover, the criteria were designed to be interlinked, recognizing the

intricate relationships between different aspects of policy effectiveness. For instance, the prioritization of the effectiveness criterion at 35 percent underscores the central importance of achieving tangible outcomes in reducing the risk of homelessness. Simultaneously, the significant weight assigned to the cost criterion at 30 percent reflects the understanding of the financial implications inherent in policy decisions. This signifies a recognition of the need to strike a balance between achieving desired outcomes and managing the associated economic considerations, emphasizing a comprehensive approach to policymaking. In essence, this process involved synthesizing theoretical insights from the eightfold path with practical considerations and contextual nuances specific to the healthcare challenges of older adults in Washington, DC. The resultant evaluative criteria, finely tuned to address the intricacies of the issue, form a robust framework that will guide a comprehensive assessment of each policy alternative, facilitating an informed and well-balanced decision-making process.

EFFECTIVENESS

The effectiveness criterion evaluates how well each policy alternative addresses the problem of reducing the risk of homelessness among older adults in DC, particularly in terms of lowering the level of poverty and the likelihood of bankruptcy due to high medical costs. The degree of poverty reduction among seniors is measured as a year-over-year percentage change, projected over five years, and is represented on an ordinal scale ranging from one to five. The overall poverty rate in DC currently stands at 13.3 percent (US Census Bureau 2023c). A rating of one on the scale indicates a low impact on poverty reduction, while a rating of five indicates a high impact.

1. 0-5 percent reduction in Poverty
2. 5-10 percent reduction in Poverty
3. 10-15 percent reduction in Poverty
4. 15-20 percent reduction in Poverty
5. 20-25 percent reduction in Poverty

COST

The cost criterion evaluates the average annual cost of each alternative for five years, with a focus on identifying potential budget reductions. The scale used to measure costs ranges from one to five, with one indicating an exponential (more than 80 percent) increase in the relevant existing budget and five indicating a minimal increase. The goal is to select an alternative that achieves significant savings while remaining financially feasible.

1. Increase the existing budget by 80-100 percent
2. Increase the existing budget by 60-80 percent
3. Increase the existing budget by 40-60 percent
4. Increase the existing budget by 20-40 percent
5. Increase the existing budget by 0-20 percent

ADMINISTRATIVE FEASIBILITY

The difficulty of implementation is assessed by measuring the level of coordination needed among agencies, private sector partners, and stakeholders during the first two years of implementation. An ordinal scale of one to five will be used to gauge the administrative feasibility of each alternative.

1. Heavy interagency coordination and/or significant stakeholder opposition, referring to stakeholders (insurance companies/healthcare providers/advocacy groups) who actively oppose the policy and are likely to mobilize against it.
2. Implementation by four or more agencies and/or moderate stakeholder opposition, referring to stakeholders who express concerns about the policy but may not actively oppose it.
3. Implemented by three to four agencies and/or some stakeholder opposition, referring to stakeholders who have some concerns about the policy but are willing to work with the government to address them.
4. Implemented by one to two agencies with little stakeholder opposition, referring to stakeholders who have minor concerns about the policy but are willing to support it.
5. Implemented by one agency with no stakeholder opposition, referring to stakeholders who have no concerns about the policy and are fully supportive of it.

POLITICAL FEASIBILITY

Political feasibility pertains to the predicted level of support or opposition from decision-makers who possess the authority to affect policy implementation. This involves evaluating whether the proposed policy alternative is likely to be accepted or rejected by those with the power to enact it. Alternatives will be measured at a four-year mark, which aligns with the typical election cycle for the mayor. An ordinal scale ranging from one to five will be used to rate the level of political feasibility of each alternative. The scale is based on the anticipated level of support or opposition, with one indicating strong opposition and five indicating widespread support.

1. The policy is strongly opposed and will not pass a committee vote.
2. The policy confronts significant opposition and will not be prioritized by the city council.
3. The policy encounters some opposition and will require negotiation and persuasion to pass a city council vote.
4. The policy faces little opposition and will likely pass a city council vote.
5. The policy has widespread support, will pass a city council or congressional vote, and will go to the Mayor or the President.

PROJECTED OUTCOMES OF POLICY ALTERNATIVES

Each policy alternative is evaluated on a scale ranging from one to five, with the highest rating being assigned to the alternative that yields the most favorable outcomes for a particular criterion. If alternatives exhibit similar outcomes within a criterion, they are assigned the same numerical value. The following section will detail the outcomes of each alternative based on the respective criteria.

1. STATUS QUO

EFFECTIVENESS

This alternative receives a rank of zero on the scale. Given the limited time for policy implementation, there is currently no clear evidence of this policy directly contributing to the reduction of poverty in Washington, DC. Hence, this alternative is considered much less effective in terms of decreasing poverty or the risk of homelessness among older adults.

COST

As per the analysis, this alternative receives a score of three since the budget increase in terms of total dollars far exceeds the percentage increase. According to a report from an independent research agency, the Medicare Part D budget experienced a 5 percent increase to account for the out-of-pocket expenditure cap for the current status quo (Cubanski and Neuman 2023, 6). The increase in budget was due to the burden of out-of-pocket costs for seniors and individuals with disabilities, who were paying more than $6,000 annually for prescribed drugs (Cubanski and Neuman 2023, 6). The implementation of the proposed out-of-pocket expenditure cap was intended to address this issue by restricting the maximum amount that seniors and individuals with disabilities paid for prescribed drugs under Medicare Part D to $2,000 annually (Cubanski and Neuman 2023, 8). This policy change was intended to reduce the financial burden associated with drug costs and improve access to affordable medications for this vulnerable group.

ADMINISTRATIVE FEASIBILITY

This alternative has been assessed with a score of one, indicating that it involves multiple agencies and complex workings.

POLITICAL FEASIBILITY

This alternative is slated to proceed as it is an existing program.

2. EXPAND MEDICARE COVERAGE BY LOWERING ELIGIBILITY CRITERIA FROM 65 TO 63 YEARS OF AGE

EFFECTIVENESS

Alternative two has undergone a thorough evaluation, resulting in a ranking of three based on the effectiveness criterion. The rationale behind this ranking is grounded in the findings of the Georgetown report, indicating a 17.1 percent point reduction in poverty when adopting Medicaid (Wagnerman 2018, 2).

Extrapolating this impact on Medicare for Washington, DC's elderly population suggests moderate effectiveness, estimating a 13.68 percent reduction in poverty among elders (as calculated from Wagnerman 2018 figures).[4] Moreover, leveraging the insights from this study and using it as evidence, there is a plausible expectation that policies focusing on expanding Medicare could also contribute to lowering overall medical costs, adding to the policy's potential positive outcomes.

COST

Alternative two ranks as a five on the cost evaluation scale as it would increase the existing budget by 15.69 percent (as calculated from Cubanski and Neuman 2023 figures).[5] Thus, it gets a rating of five, indicating that it would raise the budget by less than 20 percent. This implies that alternative two can achieve substantial savings while being financially viable, fulfilling the cost criterion objective.

ADMINISTRATIVE FEASIBILITY

Alternative two has been assessed with a score of four in terms of administrative feasibility, signifying a high level of ease in implementation. In Washington, DC, the Medicare program is federally administered through the Centers for Medicare and Medicaid Services (CMS), with the Social Security Administration (SSA) playing a pivotal role in managing the enrollment process for Medicare beneficiaries. While the local DC Department of Health Care Finance oversees the Medicaid program, it does not directly administer Medicare. Consequently, the successful execution of this alternative at the local level primarily involves coordination with federal entities, particularly CMS and SSA. This dual-agency involvement underscores the necessity for seamless collaboration between local and federal agencies to effectively implement the proposed policy change. The close interaction with CMS and SSA ensures that not only the age eligibility criteria are adjusted but also that the enrollment procedures align with the intended expansion of coverage for the targeted age group.

POLITICAL FEASIBILITY

Alternative two has been assigned a score of four. It advocates for the expansion of Medicare

coverage by lowering the eligibility age from 65 to 63, which hinges on federal legislative support as Medicare is administered through the federal budget.

In 2021, the DC Council showed support for Medicare for all resolutions (Johnson 2021). Since the proposal garners traction within Washington, DC, it can advocate for the passage of the proposal; however, its ultimate feasibility lies in garnering approval from Congress. Nevertheless, with healthcare being a significant component of federal spending priorities and increasing recognition of the importance of addressing healthcare access for older adults, there is a reasonable expectation for bipartisan consideration. The alternative also demonstrates tangible legislative precedent. In 2021, Congresswoman Pramila Jayapal introduced the "Improving Medicare Coverage Act," a bill that proposed lowering the age of eligibility for Medicare from 65 to 60 (Jaypal 2021). This legislative initiative underscores a growing recognition within Congress of the importance of expanding healthcare access for older adults. Therefore, although contingent on federal legislative processes, the proposal stands on solid ground, supported by the overarching imperative to enhance healthcare accessibility for elderly populations nationwide.

3. INCREASE INVESTMENT IN DIGITAL HEALTH TECHNOLOGY THROUGH TELEMEDICINE

EFFECTIVENESS

This alternative has been assigned a rank of three based on its potential to generate significant cost savings. According to the National Committee for Quality Assurance, telemedicine is 17 percent more cost-effective than physical visits (NCQA 2020, 5). Data provided by the Kaiser Family Foundation (KFF) reveals almost half of the Medicare budget, or 48 percent, is allocated to Part B, which mainly comprises physical visits (Cubanski and Neuman 2023, 2). With the DC Medicare budget amounting to $675,026,711,[6] adopting telemedicine can lead to substantial cost savings; based on this estimate, telemedicine could save up to $114,754,540.89 in Medicare expenditures (author calculations based on NCQA 2024; Cubanski and Neuman 2023).[7] Consequently, this alternative has been ranked three on the evaluation scale, considering it can save 100 million dollars in medical expenses. Adopting telemedicine can yield a positive impact by reducing the financial burden of medical expenses on older adults, improving their access to care, and potentially reducing poverty levels within this demographic.

COST

Alternative three has been given a rating of four due to a budget increase of 32.35 percent. There is an existing fund of $20,400,000,000 aimed at increasing broadband connectivity for all seniors in the United States to facilitate access to telemedicine (Vaidya 2023, 2). This amounts to $377.78 per adult and a total of $32,343,444.44 for all adults in DC. However, to provide access to all adults, equipment such as laptops and internet connectivity are required, costing approximately $500 per person. Therefore, the total budget to provide

telemedicine access to all adults is $42,807,500.[8] This indicates a budget increase of $10,464,055.56 or a 32.35% increase, which falls under the score of four on the evaluation scale. Despite the increase in budget, the potential cost savings from telemedicine make it a viable option for improving healthcare access and reducing medical expenses, which could indirectly contribute to poverty reduction among older adults.

ADMINISTRATIVE FEASIBILITY

Alternative three has been rated three on the scale. Even though the alternative involves a complexity of implementation involving coordination among multiple agencies, hospitals have already begun making the transition to make this process easier. Local hospitals are actively accepting Medicare patients for telemedicine. The agencies involved in the coordination include the DC Department of Health, the DC Department of Health Care Finance, the DC Department of Behavioral Health, and the Office of the Chief Technology Officer. Additionally, federal agencies such as the Centers for Medicare and Medicaid Services and the Federal Communications Commission may also play a role in coordinating and implementing telemedicine initiatives.

POLITICAL FEASIBILITY

Increased investment in tech has received a score of four as it is anticipated that this alternative will likely face little opposition in the current political landscape. DC is investing $92 million in the HOPE Initiative to improve healthcare and address disparities by creating new lab spaces and technological advancements (Executive Office of the Mayor, 2022b). Given the city's priority on addressing healthcare disparities, opposition to investment in telemedicine is unlikely from the city council and mayor.

4. INCREASE CAREGIVER SUPPORT

EFFECTIVENESS

This alternative has been assigned a rank of two. According to a report by Columbia University, the childcare tax credit program, which has increased the existing tax credit by nearly 65 percent, has helped decrease child poverty by 40 percent (CPSP 2021, 1). As an alternative, the article proposes to increase caregiver support by raising the tax credit exemption on eligible medical expenses for seniors from 30 to 40 percent. We anticipate that this change will result in a decrease of at least 10 percent in poverty among seniors. We note that the decrease in poverty is only one-fourth of the childcare tax credit, as the tax credit for a senior caregiver is half the amount provided for childcare.

COST

Alternative four has a ranking of four on the evaluation scale. Based on a report by AARP,

the estimated economic value of family caregivers' unpaid contributions was approximately $600 billion, based on about 38 million caregivers providing an average of 18 hours of care per week for a total of 36 billion hours of care, at an average value of $16.59 per hour (Reinhard 2023, 1), and under the 2021 Credit for Caring Act bill, 30 percent of eligible spending can be claimed as tax credits. With a 20 percent federal tax, the total budget to support caregivers is $36 billion, which translates to a budget of $666.67 per senior and a total budget of $57,076,666.67[9] (calculated by the author as per numbers in Reinhard 2023). for all DC seniors. However, with medical expenses increasing, the tax credit should be at least 40 percent to adequately support caregivers. With a 40 percent tax credit on spending, a 20 percent federal tax, and a budget of $888.89 per senior, the total budget for all DC seniors would be $76,102,222.22[10] (calculated by the author as per numbers in Reinhard 2023). This would require an increase in the existing budget of 33.33 percent, earning a ranking of four on the evaluation scale.

ADMINISTRATIVE FEASIBILITY

Given the involvement of two agencies, this alternative has received a feasibility score of three, indicating a relatively lower level of coordination. Implementing a policy to support caregivers by increasing tax credits would require action from both the DC government and the federal government. At the local level, the Office of Tax and Revenue, the agency responsible for implementing tax policies, would need to be involved. At the federal level, the Internal Revenue Service (IRS) would be involved in implementing any changes to tax credits. Coordination between these two agencies would be necessary to ensure that any changes are implemented smoothly and effectively. While coordination between these agencies is necessary, the involvement of two agencies makes the implementation less challenging.

POLITICAL FEASIBILITY

A score of three has been assigned for political feasibility. It is possible that increasing tax credits for caregivers of elderly people in DC may face some opposition at the city council level due to the allocation of funds from the city budget. Increasing tax credits means reducing the revenue collected by the government, which could lead to budgetary constraints and potential opposition from those who prioritize other spending areas. However, the fact that DC already invests in the Keep Childcare Affordable Tax Credit suggests that the city is willing to support tax credits as a means of addressing social welfare issues.

5. BUILD 8 ADDITIONAL SENIOR CENTERS IN DC

EFFECTIVENESS

After evaluating this alternative, it is ranked as one since it does not directly reduce poverty levels. The study by Stanford Medicine delves into the intricate dynamics between programs

targeted at enhancing the emotional well-being of older adults (Hansen 2020). The empirical investigation reveals a discernible correlation between improved emotional health in older adults and a consequential net saving of $483 million (Hansen 2020). Considering these findings, this research poses an inference that the presence and facilitation of senior centers may play a contributory role in fostering enhanced emotional well-being among older individuals. This study extrapolates the potential ramifications of improved emotional health within senior centers, suggesting a plausible pathway toward substantial nationwide medical savings, with an estimated total saving of $483 million. This academic exploration seeks to contribute to the ongoing discourse on the multifaceted relationship between emotional well-being programs, senior centers, and their broader economic implications for healthcare expenditures (Hansen 2020). Drawing from this report, we can assume that the estimated medical savings in Washington DC will amount to $765,778.[11] Thus, we can conclude that the savings fall under the category of 1-50 million dollars in medical savings. This assumption establishes a significant link between medical savings and poverty reduction, albeit an indirect one. Medical expenses can be a major burden on individuals and families living in poverty, and the availability of senior centers can help alleviate this burden. Reducing medical costs will not drastically impact the out-of-pocket expenditures for senior centers, but this alternative can contribute towards improving the financial well-being of older adults, potentially reducing poverty levels among this demographic.

COST

According to the cost criterion evaluation scale, this alternative would only receive a rating of one since it requires a budget increase of over 100 percent. The cost of the existing eight senior centers in DC is $61,418,000 (calculated by the author as shown in the footnote). Building additional nine senior centers would cost $78,966,000,[12] resulting in a 128.57 percent increase in the existing budget.

ADMINISTRATIVE FEASIBILITY

Ranking one on the feasibility scale, this alternative will require coordination and collaboration between several government agencies, including the DC Department of Aging and Community Living, the Department of Health, and the Office on Aging.

POLITICAL FEASIBILITY

Alternative five has been rated with a political feasibility score of three, indicating a moderate level of feasibility. The Mayor of DC has emphasized the importance of affordable housing and homelessness prevention in her policies, which may indicate support for initiatives aimed at preventing elderly homelessness that make DC a great city in which to grow older. However, funding for senior centers may compete with other budget priorities and may require negotiation.

TRADEOFF ANALYSIS

According to the results displayed in Table 1, the alternatives have been evaluated based on each criterion and measure. The alternative with the highest total score is indicated in bold, with its corresponding weighted score written underneath. Alternative two has received the most points with a weighted total of 3.95, making it the highest-scoring alternative. As previously mentioned, the benefits of alternative two have the potential to reduce the risk of homelessness among the elderly population in Washington, DC, by reducing poverty levels by 13.68 percent. Additionally, the program is expected to be cost-effective as it would increase the existing Medicare budget by 15.69 percent, making this alternative the most effective and least costly.

This monetary increase is comparatively lower than other alternatives. The administrative feasibility of the program is favorable, with only a limited number of agencies and partnerships required during the first two years of implementation. Finally, the predicted level of political support for the program is relatively high, adding to its overall feasibility and potential success. Alternative two is a promising step in addressing the issue of homelessness related to high medical expenses, despite the lack of extensive research on the topic. It is also worth noting that Medicare is a federal program, and its funding may be a contentious issue. Furthermore, any plan for reforming Medicare needs to contend with the potential for market failure due to the following conditions: lack of knowledge by consumers, competitive advantages to suppliers, incentives for risk selection, or the presence of social goals that the market cannot meet. Despite limited studies, evidence shows that Medicare offers substantial protection from medical expenditure risk. At age 65, out-of-pocket expenditures drop by 33 percent at the mean and 53 percent at the ninety-fifth percentile. Medical-related financial strain, such as difficulty paying bills and collections debts, is dramatically reduced (Barcellos and Jacobson 2016, 1). Therefore, it is a crucial solution to address the current issue at hand. Although alternative three, involving the increase in investment in digital health technology through telemedicine, showed promising results, it was not as cost-effective as alternative two. Additionally, alternative three would require a 32.35 percent budgetary increase from previous Medicare budgets. Furthermore, its administrative feasibility was also an issue, and limitations around technological infrastructure precluded a recommendation for alternative three at this time.

POLICY RECOMMENDATION

After carefully evaluating the various alternatives using the designated criteria and their respective weights, the author strongly suggests the adoption of alternative two to expand Medicare coverage by lowering the eligibility criteria from 65 to 63 years of age. By taking this step, we can lay the foundation for mitigating the perilous risk of homelessness prevalent among the elderly population, a risk that is closely entwined with the escalating burden of medical expenses. This strategic policy adjustment stands out as a pivotal step

in addressing the imminent threat of homelessness among older adults in Washington, DC, whose vulnerability is exacerbated by escalating medical expenses. Evidence drawn from the Georgetown Report (2018) underscores the potential impact of this policy shift, revealing a 17.1 percent point reduction in poverty associated with the adoption of Medicaid (Wagnerman 2018). Extrapolating this finding to the local context suggests a substantial 13.68 percent reduction in poverty among older adults in our community. Notably, the positive outcomes extend beyond poverty alleviation, as policies focused on expanding Medicare have the potential to contribute to a broader reduction in overall medical costs. This dual benefit positions alternative two as a comprehensive and impactful solution to the complex challenges faced by our aging population.

The administrative feasibility of this alternative is underscored by the existing federal administration of Medicare through the Centers for Medicare and Medicaid Services (CMS) and the pivotal role played by the Social Security Administration (SSA) in managing beneficiary enrollment. The proposed policy change aligns seamlessly with the current infrastructure, necessitating effective coordination primarily at the federal level, with the DC Department of Health Care Finance overseeing Medicaid.

Politically, the landscape appears favorable, with recent indications of support for Medicare resolutions within the DC Council and the recognition of healthcare as a significant budgetary concern. This favorable context positions alternative two as a politically feasible and timely solution capable of garnering support for its implementation.

In essence, the strategic move to expand Medicare coverage by lowering the eligibility age from 65 to 63 emerges as the most effective, financially viable, administratively feasible, and politically supported policy alternative. This recommendation serves as a proactive and holistic approach to mitigate the risk of homelessness linked to the financial strain of medical costs among older adults in Washington, DC.

Table:1 Weighted Policy Evaluation Matrix						
	Weights	**Alternative 2: Expand Medicare coverage by lowering the eligibility criteria from 65 to 63**	Alternative 3: Increase Investment in Digital Health Technology	Alternative 4: Increase Caregiver Support	Alternative 5: Build 8 Additional Senior Centers	Status Quo: current policies and programs in place addressing the issue
Effectiveness: Lowering the risk of homelessness by reducing the level of poverty. Reduction in poverty among seniors measured as a year-over-year percentage change. (estimated at year 5)	35%	**3**	3	2	1	1
		1.05	1.05	0.7	0.35	1
Cost:	30%	**5**	4	4	1	3
Annual cost averaged over the first five years		**1.5**	1.2	1.2	0.3	0.9
Administrative feasibility:	20%	**4**	3	3	1	1
The difficulty of implementing each alternative is measured as the number of agencies and partnerships required during the first two years of implementation		**0.8**	0.6	0.6	0.2	0.2
Political Feasibility:	15%	**4**	4	3	3	4
The predicted level of support or opposition measured at a 4-year marker		**0.6**	0.6	0.45	0.45	0.6
Total Unweighted Sum		**16**	14	12	6	8
Total Weighted Sum		**3.95**	3.45	2.95	1.3	1.7

LIMITATIONS

Providing healthcare coverage by reducing eligibility criteria would require a significant amount of funding, challenging the current budget constraints. This could also lead to an increase in taxes or a reduction in other government services to compensate for the added cost. Additionally, there could be potential stakeholder opposition to this alternative. Reducing the age requirement could seem unfair to those who have paid into the system for longer, resulting in a loss of support from these individuals. Digital health technology as a policy alternative may face limitations due to unreliable internet connectivity and the lack of technology infrastructure in certain regions. Additionally, some seniors may face difficulties in accessing devices or may not know how to utilize them. Lastly, when designing policy alternatives for the elderly population, it is crucial to consider the regional differences that exist. This analysis limits its focus to the elderly in DC, so care should be taken in generalizing its claims about the effects and benefits of this proposal beyond that jurisdiction. Seniors in different geographical locations have unique needs and resources and thus may require tailored solutions to address their healthcare challenges. For instance, elderly people living in rural areas might encounter different obstacles in accessing healthcare compared to those in urban areas. Therefore, it's necessary to carefully evaluate the varying needs of each community and implement policies that are best suited to their specific needs.

CONCLUSION

In conclusion, reducing the eligibility criteria for Medicare from 65 to 63 is a highly effective policy recommendation to address the problem of homelessness among older adults in DC. By expanding access to healthcare services, we can alleviate the burden of high medical costs and poverty that often lead to homelessness among seniors. Alternative two scored as high or higher than any other alternative on every metric, making it a clear choice for improving the health outcomes and financial stability of older adults in Washington, DC. Therefore, I strongly recommend implementing this alternative as a crucial step towards creating a more secure and healthy environment for our seniors. With an increase in homeless elders, this can be the beginning of a new cultural problem at a time when Washington, DC, is working toward making homelessness in the district rare, brief, and nonrecurring.

NOTES

[1] Adjusting the age group to 63 maintains the Medicare budget increase below 20%.
Total Medicare budget for the USA, 2021: $887 billion (Cubanski and Neuman, 2023, Fig 8)
Total Population of USA Over 65 years of age: 54 million ("America's Health Rankings Senior Report" 2021)
The current Medicare budget for people over the age of 65 is $887 billion for a population of 54 million, averaging $16,425.93 per person. Including the 63 age group adds 13,430 (number as per calculation in footnote 2) individuals eligible for Medicare Advantage. This necessitates an additional budget of $220 million, constituting approximately a 15% increase from the existing relevant budget.

[2] The total population for the age range of 60-64 is 33,577. (Babji 2024)
To find the average population for each age within this range, we divide the total population by the number of ages 60,61,62,63,64 (5), resulting in an average of 6,715.4 individuals per age.
Considering only the ages 63 and 64, the total population for these two ages combined would be twice the average.
Therefore, the population of individuals aged 63 and 64 is calculated as (2 * 6,715.4 = 13,430.8)

[3] The total population for the age range of 60 and above is 116,418. (Babji 2024). With eight senior centers and a population of approximately 116,418 seniors aged 60 and above, each center serves around 14,552.25 individuals. Assuming each senior spends 3.3 hours at the center and the daily capacity per center is 40 individuals. Consequently, seniors can visit the center once every 3.65 months. It is recommended that each ward should have at least two senior facilities. Increasing the total number of senior centers to 16 would enable at least 50% of the total senior population to visit a center once every month.

[4] Current Population (63-65): 13,430.80 ("America's Health Rankings Senior Report" 2021). Population Under Poverty (63-65): 2,216.082 ("America's Health Rankings Senior Report" 2021). Assuming Medicare will reduce Poverty By 17.1% (Wagnerman 2018) (as per Georgetown report): Total People Under Poverty after reducing Medicare age to 63 - 1,837.131978. Poverty Percentage after reducing age to 63: 13.68%.

[5] Total Medicare budget for the USA, 2021: $887 billion (Cubanski and Neuman 2023, Fig 8). Total Population of USA Over 65: 54 million ("America's Health Rankings Senior Report" 2021)• Total per person Medicare cost: $16,425.93 (887 billion/54 million). People in DC 65 and above 85,615 (Babji 2024). Existing Medicare budget for DC seniors: $1.41 billion; (85615 X 16425.93). Washington DC Population Between 60-64: 33,577 (Babji 2024). Population aged 63 and 64: 13,430.80 (Babji 2024). Total Budget to expand medical coverage by reducing the age group to 63: $220.61 million = 15.69% of the current budget.

[6] Total Medicare budget for the USA, 2021: $887 billion (Cubanski and Neuman 2023, Fig 8). Total Population of USA Over 65: 54 million ("America's Health Rankings Senior Report" 2021). Total per person Medicare cost: $16,425.93 (887 billion/54 million). People in DC 65 and above 85,615 (Babji 2024). Existing Medicare budget for DC seniors: $1.41 billion; (85615 X 16425.93). 48 % of the Medicare Budget is part B = 675,026,711.

[7] Telemedicine is 17% cheaper than Physical Visit (NCQA Report). 48% of the Medicare budget is for Part B, which is a physical visit. (Cubanski and Neuman 2023). 48% of DC Medicare Budget = $675,026,711.11 (calculation taken from footnote 5). Thus, total Medicare savings by adopting telemedicine = $114,754,540.89.

[8] Total Population of USA Over 65 = 54 million ("America's Health Rankings Senior Report" 2021). Existing Fund To increase broadband = $20,400,000,000.00 ((Vaidya 2022, 2). People in DC 65 and above 85,615 (Babji 2024). Funds Per adult = $377.78. (Existing fund to increase broadband/population of USA over 65). Funds for all adults in DC = $32,343,444.44; (funds per adult * 65 and above population in DC). To Provide access, all adults will need equipment. Laptop = $400.00 and Internet connectivity = $100.00; Total = $500.00. Total Budget to provide telemedicine access to all adults = $42,807,500.00. Budget Increase = $10,464,055.56 = 32.35%.

[9] Total Family spending in caregiver support = $600 billion (Reinhard 2023)
Per this Bill, 30% of eligible spending can be claimed as tax credits = $180,000,000,000.00 ("H.R.3321 - 117th Congress (2021-2022): Credit for Caring Act of 2021", n.d.). Assuming a 20% federal tax on the credit, the total budget to support Caregivers = $36 billion. (180 billion*20). Budget for one senior = $666.67 (36 billion/Total Population of USA Over 65, which is 54 million). Budget For all DC seniors = $57,076,666.67 (budget for one senior, 666*people in DC 65 and above, 85,615 (Babji 2024). Increase = $10,464,055.56 = 32.35%.

[10] Total Family spending in caregiver support = $600 billion (Reinhard 2023). With medical expenses Increasing, the tax credit should be at least 40% to support the caregivers= $240 billion (600billion *40%). Assuming a 20% federal tax on the credit, the total budget to support Caregivers = $48 billion (240 billion*20). Budget for one senior = $888.89 (48 billion/Total Population of USA Over 65, which is 54 million). Budget For all DC seniors = $76,102,222.22 (budget for one senior, 888*people in DC 65 and above, 85,615 (Babji 2024). Increase = $19,025,555.56 = 33.33%.

[11] Senior centers can help in countrywide savings of $483 million (Hansen 2022). Saving per adult = 483 million/ total population of USA over 65; which is 54 million = $8.94. Thus, total medical savings in DC = Saving per adult (8.94)*Population in DC 65 and above (85,615 Babji 2024) = $765,778.

[12] Assuming the total area of 1 senior center = 20,000 sq ft. Land cost $90/sf = 1,800,000.00 (Rane, Paroma 2024). Construction cost is $283/sf = 5,660,000.00 (total area of 1 senior center*283) (Scalisi, Tom 2020). Operating cost for $90 per adult per day; assuming 40 adults per day = 1,314,000.00 ("Facts on Adult Day Care" 2023). Total cost for one adult center = 8,774,000.00 (sum of land, construction, and operating cost). Existing budget/cost for existing 8 senior centers = 61,418,000.00 (cost of 1 center*7). Total cost for additional 9 centers = 78,966,000.00 (cost of 1 center*9). Increase = 128.5% (Cost of 9 centers/cost of existing eight centers).

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