MICHIGAN IN REVIEW:
Long Term Services and Supports
August 2019
LeadingAge Michigan: Focus on Five!!

The Healthcare System and in particular LTSS has been in a continuing ‘crisis’ for the past many years: where do we go from here? LeadingAge Michigan is driving discussion about senior services and the not-for-profit difference.

LeadingAge Michigan is proposing FIVE priorities for 2019-2022:

1. **Charitable Purpose** – We must maintain support for our communities that are mission-driven with a higher purpose to serve. Local and other taxing agencies have been attacking not-for-profit charitable purpose, based on the legal definitions here in Michigan. It is critical that we continue our ability to provide higher quality of care and prioritize quality of life over profit maximization.

2. **LTSS System Design and Managed Care** – With the recent trends toward managed care in both Medicare and Medicaid, it is critical that we ensure that these programs work to support the provider in delivering an appropriate level of care and minimize cost shifting.

3. **Regulatory Burden** – Incremental increases in regulatory burden over time have brought us to an almost crisis point. We need to elevate and escalate the conversation about what really works to protect residents.

4. **Housing** – Safe and affordable housing is one of the most important social determinants of health. Public funding is diminishing for the senior, and senior poverty overall is affecting their ability to find secure housing.

5. **Workforce** – We are facing a future of increasing senior numbers, and decreasing potential workforce that has already begun to impact senior care providers. It is essential that we fully understand the true causes of poor recruitment and retention to focus industry planning.
LeadingAge Michigan draws its mission from its members who focus wholeheartedly on service to seniors. We are the only statewide Association poised to advocate for the entire array of post-acute and long term services and supports providers, while guided by prudent stewardship.

The next few years will be decidedly challenging as we attempt to serve larger numbers of seniors with fewer caregivers and potentially fewer health care dollars. We feel we are at the very edge of crisis now as provider regulatory burden and associated costs are escalating, caregiving staff are harder and harder to find, and barriers to payment are growing. The multitude of payers and alternative payment programs, while intended to improve care and services for seniors, are also a challenging barrier to ensuring adequate resources to maintain our viability.

Michigan has yet to decide its path through all the confusion, and there are many different stakeholders with differing incentives and goals. The sooner that the state thoroughly addresses the many LTSS issues in front of us, the better prepared we will be for the next decade.

The State of LTSS in Michigan:
This review compares Michigan performance to several peer states, and also two LTSS best practice states: Washington and Minnesota. In summary, we find:

- Michigan overall LTSS performance that ranks slightly better than median (22nd among states and District of Columbia) (LTSS State Scorecard, 2017)
- Diminished overall population growth in Michigan due to outmigration against a growing aging population (US Census, 2019)
- Increasing ethnic and cultural diversity that impacts both patients and caregivers
- Significant variation in proportion of HCBS used across the state (CHRT, 2018)
- Long waiting lists for MI Choice Program services and affordable housing (MDHHS, 2019)
- Improving performance over time in access to home and community based services along with a downward trend in nursing home bed days (LTSS State Scorecard, 2017)
- Reliance on a fragile and risky Provider Tax Mechanism (A full review of provider tax issues can be reviewed in LeadingAge Michigan Primer on Provider Taxes – 2019)
Cost/Funding

- Michigan ranks 29th in percent of funds going to HCBS (LTSS State Scorecard, 2017)
- 32nd in amount of total Medicaid LTSS spending per senior/adult with disabilities (AARP, 2018)
- 46th in the amount of Medicaid LTSS spending per capita (AARP, 2018)
- A respectable annual increase of 4.3% in budgeted funding for Medicaid LTSS between 2013-2019 (CHRT Report)

Access

- Michigan ranks 9th in the country in nursing home transitions to community (LTSS State Scorecard, 2017)
- Respectable performance in percent of new nursing home stays that last 100+ days (LTSS State Scorecard, 2017)
- Moderate use of nursing homes per 1000 seniors, ranking 26th (AARP, 2018)
- Michigan nursing home occupancy average of 82%, and Michigan continues to be over-bedded in urban areas (KFF, 2019)

The MI Choice Program and PACE have expanded over the past several years, and yet waiting lists for MI Choice persist while PACE slots at times remain open. PACE is one of the most effective programs for frail seniors and could be used as a model to expand managed long term services and supports. Recent federal PACE program changes should decrease some of the barriers to enrollment. There is wide variation in use and access to home and community based services in Michigan, and an analysis of MI Choice slot distribution or rural resources may well be warranted. The Chart below identifies budgeted funding for these two programs over the past several years.

![Michigan Budgeted Funding in Millions](chart.png)

*Michigan Senate Fiscal Agency Report 2019*
There was no individual line item for PACE funding for FY 2016. It appears it was included with LTSS Integrated Care Budget. The Association has consistently driven advocacy for increased funding for these two HCBS programs, in an environment where the state General Fund has remained relatively flat.

**History of LTSS Reform and Integrated Systems in Michigan**

Like other states, Michigan’s LTSS system developed over time and subsequently has grown in fragmented ways, with resulting silos and barriers between programs. Historically, there has never been any Medicaid FFS program that has funded care coordination across programs based on individual consumer needs. This has only reinforced a structure that does not work across the entire array of services.

To address many of these problems and move forward in terms of person-centered and more efficient care, Michigan has embarked on a path of numerous initiatives over the past two decades – many of which have failed. The latest initiative is a move to managed long term services and supports. While there are positive goals and some positive findings for this program, *MI Health Link* – Michigan’s Demonstration to Integrate Services for Persons with Medicare and Medicaid - has failed in the view of many consumers and providers. In summary, stakeholders in general have identified several areas of concern (CHRT, 2018). A deep analysis of managed care issues can be reviewed in the *LeadingAge Michigan Report: State of Managed Care*.

**MI Health Link - Health Plans (CHRT Report)**

- Health plans demonstrated poor understanding of the needs of the LTSS population from the start. A simple attestation of LTSS experience was not adequate
- Health plans often denied a large number of claims on first review, even after pre-authorization, which were overturned on appeal but then delayed payments to providers
- Most stakeholders identified with the goals of managed LTSS, but were critical of moving responsibilities to health plans
- History of a significant number of consumer dis-enrollments speaks to the poor performance of health plans
- Care coordination models were inconsistent and not necessarily designed for higher need populations; many patients did not know who their care coordinator was
- Health plans were often inaccessible to patients or providers when problems occurred
MI Health Link- Structural Issues

- The program failed to achieve many of the goals for which the program was intended – it is not clear that MDHHS included stakeholder concerns and
  - Addressed the issues of conflict-free options counseling, and standardized processes for person centered planning, assessments, care management, and quality measurement that managed care should address
  - Provided adequate information to passive enrollees about options. and
  - Did not fully integrate behavioral health services
- Many stakeholders were concerned that the state prioritized streamlined administration over quality of care or patient satisfaction

The issue of consistent options counseling is important as many information sources historically have not identified all consumer options, and often do not mention the PACE program at all.

The CHRT Report was an MDHHS-contracted evaluation of LTSS including MI Health Link completed in late 2018 that identified since the final CMS evaluation report (RTI Report) has not been published, a particular model for Michigan could not be recommended by researchers and it was too early to judge any success.

LeadingAge Michigan believes that there has been a rush to a particular model – a capitated CMS Financial Alignment Model that utilizes Health Plans with little experience in LTSS to coordinate care. There are other models of care and best practices that should be thoroughly reviewed before moving forward. We anticipate the official CMS/RTI evaluation due later this year and we plan to review closely to track real success for the consumer, but currently we believe that there is not sufficient support to expand or extend MI Health Link. Health Plan advocates can cite positive findings from a few managed LTSS programs in other states, but outcomes have really been mixed. Michigan should take time to identify the right program for our state.

At the same time, we strongly believe that Michigan is at a crossroads and must prepare for the future of LTSS. We believe that ongoing analysis of the system is warranted rather than conducted only intermittently, and should be studied on a regional as well as statewide basis.
Choices for all services are not always available across the state and access to HCBS is variable. We should be developing regional plans for access and quality.

While LeadingAge Michigan also believes that we have incrementally improved our system over the past decade, we also agree with the CHRT report that certain structural issues must be addressed before any move to large programmatic change: conflict-free information, referral, and options counseling; standardized outcome measurement across all LTSS programs; full integration of LTSS services including behavioral health using providers with long experience in each service area; and standardized assessment, person-centered planning, and care coordination models.

Additionally, while we would not want to replicate the long and drawn out Long Term Care Task Force of 2004, we also believe that MDHHS needs to address these consumer and stakeholder concerns.

**LeadingAge Michigan LTSS Access Recommendations:**

- **No further expansion or extension of MI Health Link until objective research demonstrates that it truly works for Michigan**
- A routine regional analysis of programs for access, quality, and cost across the state with specific attention to duplication of services and regional revenue streams for LTSS
- The evaluation of MI Health Link must include how any savings were achieved and demonstrate how the MI Health Link population (55% of which is under age 65) is really comparable to other senior programs
- Increased MI Choice funding to eliminate the waiting list
- A moratorium on new nursing home construction
- Review and analysis of access to affordable senior housing; adequate senior housing is a primary social determinant for positive outcomes
- Significant structural changes to the LTSS system overall, including:
  - An independent, conflict-free information, referral, and options counseling system that is not tied to any provider or service coordinating agency
  - Development of an integration/care coordination model that supports the Triple Aim of Better Health, Better Experience, and Reduced per capita cost but works at the local and regional levels
  - An interoperable system for data exchange and management across the system
  - Standardized tools for assessment and level of care needs
  - Standards for person-centered care that must be utilized and evaluated
  - Transparency in data across all systems; annual published reports that identify challenges, outcomes, spending for programs and integrated models
Quality and Performance in Michigan LTSS

Unfortunately, only a few LTSS programs can be reviewed for consumer outcomes and performance because most programs do not generate publicly reported data. Michigan does perform fairly well for both nursing homes and home health in comparison to other states. Nursing home readmission rates are slightly higher than the national average, but in general there is a wide variation in both quality and cost for nursing home care across Michigan. Following a proliferation of new for-profit, poor quality home health providers in Michigan over the last decade, CMS placed a moratorium on new agency certifications that was recently lifted.

LeadingAge Michigan members outperform in most areas based on the CMS Five Star System for Nursing Homes. Reviewing data from the MDHHS variable cost report from September 2018, we note a $30 per day difference between the average rate for 1 (one) star facilities and the average rate for 5 (five) star facilities. The chart below identifies the proportion of facilities who rated a 5-Star Ranking in June 2019.

For nursing homes, Michigan has demonstrated varied and vacillating performance compared to other CMS Region V states and Region V states often fare less well in terms of performance compared to other CMS Regions. Michigan notes a long history of facilities with trends of high performance over time, and low performance over time. Regulatory burden is significant since survey and certification oversight sets the bar at the level of low performing facilities.

After years of provider frustration, and consistent poor performance from some facilities, LeadingAge Michigan believes that we need to identify more innovative ways to assure a safe environment for our seniors that actually deliver desired outcomes.
LeadingAge Michigan Quality Recommendations:

- Use the standardized CMS Quality Reporting Program measures for all state programs: homes for the aged, adult foster care, Home Help, MI Choice Waiver, MI Health Link
- Create transparency in data across all LTSS programs; development of an annually published report that identify quality challenges, outcomes, spending for programs and any integrated models
- Elevate and escalate the conversation about the efficiency and efficacy of the survey and certification process at state and federal levels – without undermining the capability of the state to deal with low-performing providers
- Review LeadingAge’s Broken and Beyond Repair Report and update issues that cause burden to high performing providers
- Stop dependence on annual survey visits that can be anticipated; increase timing between annual visits for high performing providers
- Utilize focused random visits for facilities who are trending poorly, using LTC ombudsman if necessary
- Use a LTC Ombudsman across all venues
- Improve reporting methods for facility reported incidents that include all the necessary information about follow up actions to the incident and any necessary reporting to public enforcement agencies to better prioritize need for on-site visits
- Monitor performance trends over time to address poor performers who move in and out of significant compliance problems in consistent SQOC (Substandard Quality of Care) areas
- Require licensure and/or oversight of home health and personal care for participant safety
Direct care workers are the very center of the LTSS delivery system, and Michigan like other states is nearing that crisis point where there are not enough workers to serve our senior population. The Michigan working-age population is decreasing proportionally to the aging population. Michigan ranked 29th in Family Caregiver Burden (LTSS State Scorecard, 2017) which ultimately impacts reliance on paid caregivers. Stagnant wage levels for Michigan direct care workers are identified in the chart below.

The path to a sufficient and trained workforce across the industry is challenged by a number of issues:

- High regulatory environment
- Poor industry image
- Overall work environment across the industry
  - Often poor supervision and management
  - Hierarchical and top down communication
  - High proportion of injuries among nursing home workers
- Limited training and mentoring
LeadingAge Michigan Workforce Recommendations

To prepare for LTSS in the 21st century, it is important that Michigan form a vision for training and support to formal and informal caregivers. Specific initiatives must be developed to identify programs that will strengthen and support recruitment, retention, training, and mentoring.

- Michigan support of initiatives that will review the breadth and depth of issues and validate what truly drives recruitment and retention issues across the industry
- Protection of expanded Medicaid benefits and tax credits that allow direct care workers to obtain health insurance coverage
- Revision to CNA Michigan training programs and onboarding requirements
- Funding for successful training models, standards, and curricula for aides, through grants
- Pilot training programs for certain conditions such as diabetes and Alzheimer’s
- Processes to gather better data to measure Michigan workforce volume, stability, compensation, turnover, vacancy rates, wages, and benefits
- Consideration to use an Abuse Registry to identify CNA staff with a history of abuse, with confining criminal charges to persons who intentionally are abusive to seniors
- Promotion of improved performance by managed care plans ensuring adequate rates, quality strategies, performance measures, improvement projects, and mechanisms to identify enrollees with high needs
Michigan in Review 2019
Michigan Demographics, Access, and Utilization

The State of LTSS in Michigan
For decades, Michigan’s peer states were considered to be Pennsylvania, Ohio, and Illinois – all highly industrial and well-populated and used for comparison and benchmarking. Additionally, comparisons for long term services and supports generally included Minnesota and Washington as best practice states. For this report, we have utilized a different set of states that are currently more similar to Michigan in population, number of nursing homes and gross domestic product: Georgia, New Jersey, North Carolina and Virginia. These are the state comparisons that will be found in the body of the report as well as comparisons to the two consistent best-practice states – Minnesota and Washington. These two are identified in green in comparison graphs below.

Michigan Population – The Senior Crisis
Michigan’s overall population has not kept pace with the 2005 projections put forward by the US Census Bureau, mostly due to heavy outmigation of working age individuals when the economy and access to jobs trended downward. This increases the expected proportion of seniors in the state as the baby boomer population ages and the economic downturn caused persons to move elsewhere. As of 2017, Michigan noted an increase in its overall population (a rather small 0.9% increase), with a net increase in migration as well. Domestic migration continues to be negative, but international in-migration is the major source of population growth. There had not been positive net migration since the year 2000.

Michigan is still on course to double the number of persons age 85 and older between 2005 and 2050, and persons age 65 and older will account for approximately one-fifth of the population by 2030. The growing proportion of the senior population in comparison to the primary formal and informal caregiver population (44-64) continues to cause concern. The chart below describes the US population projections to 2060 and compares the proportion of growth among the age groups.
Population projections for Michigan through the year 2045 demonstrate a significant population shift with the age group of 64 and younger declining and the age group 65+ increasing by more than 877,000 persons as shown below. Michigan’s senior population (persons over age 65) is 17.2% of the population in 2018, compared to a national average of 16.0% (US Census Bureau, 2018).

Additionally, most states including Michigan continue to see growing numbers of persons with disabilities, mostly due to increases in proportion of older persons. According to the 2017 American Community Survey, 15.9% of Michigan’s population are currently 65 and older and 35.4% of those seniors live with a disability. By the year 2045, an estimated 342,000 of Michigan seniors will be living with at least one disability and almost one third of them will be living alone. Persons living with Alzheimer’s disease in Michigan is projected to rise to 220,000 by 2025.
**Poverty**

Unfortunately, the Detroit-Warren-Dearborn metropolitan area has one of the highest poverty rates of populous metropolitan areas in 2017 according to the American Community Survey. Michigan’s poverty rate of about 14.2% puts it higher than the national average of 12.3% (American Community Survey, 2016). For persons over age 65, about 21% live in poverty, and more are struggling to meet monthly expenses although they do not meet the federal poverty level. (NCOA, N.D.) These findings will put more stress on public funding as seniors age.

**Demographic Diversity**

Over the next several decades, Michigan should anticipate increased diversity in most of its communities. Between now and 2060, Michigan’s Hispanic population will more than double, even though overall Michigan population growth is anticipated to be lower than many other states. The nation is becoming more and more diverse with time which will impact both employee and patient issues. As reported in the two graphics below, diversity is growing and varies across regional areas but recent changes have been noted in the least diverse areas.

The fastest growing segments of the US population are Asian and mixed-race person according to the US Census Bureau. Non-Hispanic whites are the only segment of the population where deaths outpace births – a decrease of 163,300 across the nation between 2015 and 2016.

![US Percent of Population Growth by Ethic Group 2015-2016](image.png)

*US Census Bureau, 2017*
Access to Care/Utilization and Cost
Michigan Medicaid LTSS spending would logically be expected to reflect both increases in the cost of goods and services over time as well as the proportional gains expected in the senior population. The graphic below identifies the total amount of LTSS budgeted funding for the past several years. Individual LTSS program budget trends are included in this Chapter’s Appendix. Note that the average annual increase for budgeted funding across this time span was 4.3%.
Enrollment trends for the major Michigan Medicaid LTSS programs are included below. Note that Adult Home Help and nursing home usage has been trending slightly downward.

Starting in 2015, Michigan implemented its Demonstration Project for Integrating Services for Persons with Medicare and Medicaid (MI Health Link). Enrollment for that program is separated out below and has increased over time as the program developed.
It is important to note that while the evaluation for the MI Health Link program is not scheduled to be released until late 2019, any comparisons for cost and quality among MLTSS programs must be evaluated against performance for a similar population with a specific review of the source of savings. Consideration should be given to the relatively small number of enrollees at the nursing facility level of care within MI Health Link, along with the balance in home and community based services. Approximately 33% of MI Health Link enrollees at the NFLOC are receiving home and community based services compared to 43% within the Medicaid Fee-for-Service Programs.

A 2017 report (Picking up the Pace of Change: a State Scorecard on Long Term Services and Supports for Older Adults, People with Disabilities, and Family Caregivers) identified that there have been improvements over the past decade in access to long term care, but those improvements are not consistent across states. Michigan scored 22nd (better than median) in overall LTSS System Performance among 50 states and the District of Columbia. Michigan markedly improved its rank from 31st in both the 2011 and 2014 versions of the scorecard. Note that where the 2017 ranking is identified, it generally represents the state of performance using 2014 data. For certain indicators, more recent data is available through the AARP Across the States 2018 Report and are used within our review when appropriate.

In the 2017 report, Michigan ranked 27th among the states and the District of Columbia in overall performance in terms of access to long term programs – performance that hovers about the median. A number of indicators feed the Michigan rank of 27th in access to LTSS. Of note, Michigan ranked 37th in the number of Medicaid LTSS beneficiaries per 100 persons with ADL disabilities which means that care and services for a preponderance of adults with significant disabilities is supported outside of the Medicaid system. However, Michigan ranks 10th in percent of very low income adults (below 250% of the Federal Poverty Limit) with disabilities who receive Medicaid, better than both best practice states.
One of the most important indicators for performance in access to long term supports and services is the percent of Medicaid state LTSS spending on home and community based services. Michigan showed marked improvement and ranked 29th (31%) in that measure with a 7.7% increase from 2011 to 2016 according to the AARP 2018 Across the States Report.

Michigan also scores very well in the percent of persons with 90+ day nursing home stays successfully transitioned back to the community, scoring 9th in rank for the fifty states and District of Columbia with a rate of 9.4% compared to a median of 7.4%. Michigan performance has been supported by a federal program called Money Follows the Person, which assisted in funding transition costs. Because of the sunset of that program, Michigan moved its transition program to a 1915(i) state plan service. As of March 2019, a bipartisan group in Congress is working to extend the program until 2023 with new requirements and reporting rules.
Michigan has improved its performance in the percent of new nursing home stays that last 100 days or more to 17.6% from 20.8% using the most currently available data from 2012. Both transition and nursing home utilization data have a longer lag period than other indicators.

It is important to note that Michigan hovers around the median (26th) in terms of amount of Medicaid LTSS users placed in nursing homes per 1000 persons (65+) in the total population, and ranks 18th (with only 37 states reporting) in terms of use of home and community based services per 1000 persons aged 65+.
Michigan hovers around the median performance for the number of persons in nursing homes per 1000 seniors and ranks 18th with 37 states reporting in the number of persons receiving Medicaid home and community based services.

Based on 2016 AARP Across the States data, Michigan ranks 46th among the states and District of Columbia in the total amount of Medicaid LTSS spending for all populations, spending $319 per capita compared to a high of $1,334 in New York. **Compared to other states, Michigan has relatively low levels of utilization and low levels of Medicaid spending per capita.**

Although Michigan has moderate levels of nursing home utilization and increasing proportions of NFLOC level consumers in home and community based services, there is huge inconsistency in use and access across the state. The 2019 CHRT Report based on MDHHS Actuarial Division Data identifies five counties with 6-9% of NFLOC individuals receiving HCBS and six counties with 56-83% of NFLOC individuals receiving HCBS – with wide variation in between.

Several years ago, the Michigan Department of Health and Human Services refined its nursing home bed need methodology. In May 2019 the Department estimated that net excess beds totaled 7,586 across the state - or 7,935 across 69 counties/areas. Over the past five years the number of individual facilities has trended upward to 444, although that is a decrease from 2018 at 448. However, overall bed occupancy hovers around 81% across the nation, and about 82% in Michigan based on 2016 data (KFF, 2017). Michigan Medicaid funds approximately 60% of nursing home residents in 2016 which accounts for approximately 55% of total Medicaid LTSS funding in the state, according to the Kaiser Family Foundation (2017).

As noted in the Chart below, most ‘over-bedded’ Michigan areas are highly urban. Decreases in nursing home occupancy across facilities as noted in Michigan and elsewhere can lead to inflated Medicaid cost (Laes-Kushner, 2018). Recent discussions with the Michigan Department of Health and Human Services indicates that after a several years of declines there has been a small increase in Medicaid bed days during 2018. It is clear that the availability of beds alone has an impact on utilization, and this may be the time to consider a moratorium on new nursing home construction, or a mechanism to close down beds in certain areas.
Michigan Department of Licensing and Regulatory Affairs, 2019

Top 10 Michigan Counties/Areas with Excess Nursing Home Beds

Michigan Nursing Home Occupancy Trends

Kaiser Family Foundation, 2017
Since individuals are living longer, many are also working to later age, and many are staying more active. According to the American Community Survey, older persons are more likely to live alone in community settings as they age. Forty percent of seniors age 85 and older live alone, but this age group is also more likely to live in a group residential setting.

### Living Arrangements by Age US, 2016

<table>
<thead>
<tr>
<th>Age</th>
<th>Residential Group Setting</th>
<th>Living alone in a household</th>
<th>Living with family in a household</th>
<th>Living with non-family in a household</th>
</tr>
</thead>
<tbody>
<tr>
<td>85+</td>
<td>40.0%</td>
<td>40.0%</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>75-84</td>
<td>30.0%</td>
<td>50.0%</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>65-74</td>
<td>20.0%</td>
<td>60.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>65+</td>
<td>10.0%</td>
<td>70.0%</td>
<td>20.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Total Population</td>
<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Access to safe and secure housing is an issue for many seniors, and Michigan ranks 35th in the number of subsidized housing opportunities as a percent of all housing units (5.2% compared to 4.9% baseline rate) (LTSS State Scorecard, 2017). Many subsidized housing options have long waiting lists in Michigan and housing options with services are generally only available as a privately paid service. See Chart below.

### Subsidized Housing Opportunities as a Percent of All Housing Units

2017 Rank 35th

<table>
<thead>
<tr>
<th>State</th>
<th>2017 Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>5.0%</td>
</tr>
<tr>
<td>Michigan</td>
<td>5.4%</td>
</tr>
<tr>
<td>Virginia</td>
<td>5.3%</td>
</tr>
<tr>
<td>Georgia</td>
<td>5.8%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>5.5%</td>
</tr>
<tr>
<td>Washington</td>
<td>6.0%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Median = 5.8%

**LTSS State Scorecard, 2017**
Other Aging Services

The Michigan Legislature also appropriates state general fund/general purpose funding for aging service programs supported by the Older Americans Act along with other federal funding sources and under the auspices of the Aging and Adult Services Agency (AASA). For FY 2018 state funding for aging services under this agency increased by $3.6 million for in-home and nutrition services, specifically. These two services are pivotal for helping older adults remain in their home with independence, providing a community-based alternative to institutionalization as a sole care option.

AASA’s FY 2018 budget appropriation (combined federal and state funds) was $109,650,200. With this appropriation, more than 40 different types of access, in-home, community, caregiver, and nutrition services were provided throughout our state – services vital to the independence, autonomy, and dignity of those receiving them. Funding for these services is distributed to regional area agencies on aging through an intra-state funding formula that is based on population, poverty, minority, and geographic factors. This formula is reviewed every five years to determine the statewide impact of shifting demographics on funding allocations, and a comprehensive funding formula review took place in FY 2018.

Specifically during 2018, the Agency prioritized transportation policies, direct care worker issues, elder abuse and neglect, and work toward eliminating waiting lists for home-delivered meals and in-home services.

In support of family caregivers, during FY 2018 6,828 caregivers were supported by 810,817 hours of adult day care, respite care, counseling services, training, and supplemental care through the aging network. AASA provides significant resources to provide in-home services including homemaker and personal care services as identified below.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Clients</th>
<th>Hours/Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>3,654</td>
<td>26,461</td>
</tr>
<tr>
<td>Case Coordination and Support</td>
<td>10,933</td>
<td>61,685</td>
</tr>
<tr>
<td>Chore Services</td>
<td>3,466</td>
<td>52,484</td>
</tr>
<tr>
<td>Homemaker</td>
<td>9,873</td>
<td>557,710</td>
</tr>
<tr>
<td>Personal Care</td>
<td>4,326</td>
<td>295,275</td>
</tr>
</tbody>
</table>

AASA FY 2018 Annual Report, January 2019

AASA also administers and coordinates a large number of programs for persons in the community in addition to the services noted above that focus on addressing functional care needs, similar to Medicaid LTSS programs.
Discussion and Summary
There is a large focus on nursing home utilization since it is a significant portion of the budget, and more information is generally available about nursing homes and home and community based services as publicly funded programs. Utilization has decreased in both nursing homes and the Adult Home Help program. We expect continued contraction of nursing home usage for the time being, however recent data identifies an increase in Medicaid funded nursing home days. We are unclear about causes for the fewer persons in the Adult Home Help Program – the largest home and community based services program funded by Medicaid in Michigan.

However, with slowly increasing funding for MI Choice and PACE, and generally decreasing use of nursing homes, Michigan seems to be moving in the right direction. Coupled with comparatively low levels of spending across Michigan LTSS, we also note that federal funding significantly enhances support to the program through the nursing home provider tax.

LeadingAge Michigan has consistently supported additional funding for home and community based services. The chart below indicates the growth of Michigan nursing facility budgets compared to funding for all other LTSS programs – largely home and community based programs. Michigan currently ranks 29th in the proportion of funds going to HCBS, improved from a 2014 ranking of 40th, according to the 2018 AARP Across the States Report.

Recent policy efforts have improved funding for both PACE and MI Choice, although some PACE programs have difficulty filling all their slots, presumably due to some barriers to admission such as the requirement to change physicians and utilize only a small network of specific providers.

With the projections for high growth in senior populations for Michigan and elsewhere, it is critical that we look at the system overall and determine how best to serve our seniors and taxpayers in the future. While the focus has generally been on identifying models of care that provide aggregate savings, we think it most important to identify practices that will improve health and the experience of care on a per person basis.
This review compared Michigan performance to several peer states, and also two LTSS best practice states: Washington and Minnesota. In summary, in terms of cost and access, we find:

- Diminished overall population growth in Michigan due to outmigration against a growing aging population (US Census Bureau, 2019)
- Increasing ethnic and cultural diversity that impacts both patients and caregivers (US Census Bureau, 2017)
- Significant variation in proportion of HCBS used across the state (CHRT, 2018)
- Waiting lists for MI Choice Program services and affordable housing (MDHHS, 2019)
- Improving performance over time in access to home and community based services along with a downward trend in nursing home bed days (LTSS State Scorecard, 2017)
- Reliance on a fragile and risky Provider Tax Mechanism that continues only at the whim of Congress
- AARP (2018) reports Michigan ranks 29th in percent of funds going to HCBS
- A rank of 32nd in amount of total Medicaid LTSS spending for older persons (AARP, 2018)
- A respectable annual increase of 4.3% in budgeted funding for Medicaid LTSS between 2013-2019 (CHRT, 2018)
- Michigan ranks 9th in the country in nursing home transitions to community (LTSS State Scorecard, 2017)
- Respectable performance in percent of new nursing home stays that last 100+ days (LTSS State Scorecard, 2017)
- Moderate use of nursing homes ranking 26th among states
- Michigan nursing home occupancy averages of 82%, and Michigan continues to be over-bedded in urban areas

MI Choice (Michigan’s 1915c Waiver Program for the Elderly and Disabled) has performed very well in transitioning beneficiaries from nursing homes to the community. The graph below identifies the total number of nursing home transitions by year.

![Number of Michigan Nursing Home Transitions by Year](MDHHS, 2019)
LeadingAge Michigan LTSS Access Recommendations:

- Ongoing review of LTSS access and utilization across the state; use of the LTSS Feasibility Study (2019-2020) to develop baseline data
- Increased MI Choice funding to eliminate the waiting list
- A moratorium on new nursing home construction
- Review and analysis of access to affordable senior housing; adequate senior housing is a primary social determinant for positive outcomes
- For a review of recommendations for Medicaid Managed LTSS – see the executive summary and Leading Age Michigan Report – State of Managed Care
Quality and Performance in Michigan LTSS

In general, only nursing homes, home health, hospitals, and health plans have published performance data. Although the CMS Five Star System (for nursing homes, hospice, and home health) and the Survey and Certification Findings for nursing homes are considered by some to be largely subjective, the systems do identify the high and low performing providers rather well. On average, Michigan providers score fairly well in many areas. For programs without public funding and published performance data, it is difficult to quantify and compare findings across provider types.

The most significant CMS Quality Measures for nursing home performance include short term stay readmission rates, short term stay ER visits; and short term stay improvements in mobility. Outcomes for these three measures are fairly consistent across the peer states, with some variation in mobility as noted below. For ER Visits and Improved Mobility, Michigan performed at or better than the national average, but slightly worse than the national average for Readmissions. For Readmissions and ER Visits the lower the number the better; for improvement in ability to move around on their own, the higher the number the better.

![Select 2019 CMS STS Quality Ratings for Five Peer States](image)

For long stay measures, most significant areas include falls with major injury and high risk residents with pressure injuries. There is much more variability within the long stay measures, with Michigan performing near the national average. For each of these measures, the lower the score the better.
Looking at Michigan nursing home performance in 2017, there continues to be a marked difference in overall quality between LeadingAge Michigan Members and non-members. The following graphs identify key indicators measured by the Centers for Medicare and Medicaid Services. LeadingAge Michigan members continue to demonstrate a level of care and services that make them premier providers of senior care and services.
While LeadingAge Michigan members outperform non-members in health inspection (survey) outcomes, there are fewer five star facilities for this category. This speaks to the ongoing issue with the huge regulatory burden in an era marked by resource and financial strain, and supports the need for rethinking the nursing home regulatory system. Regulations are obviously the result of the number of poor performing providers, which continue to exist in Michigan as elsewhere. But such a burdensome regulatory system makes it harder for the high performing nursing home provider to serve seniors.
Several years ago, a large number of new home health agencies sprung up in Michigan and CMS questioned the performance and quality of many of these mostly for-profit agencies. The federal government placed a moratorium on certified home health agency development first in Detroit and then the rest of the state. That moratorium was lifted in January 2019.

Home Health Care quality findings, also documented on the CMS Compare website, include measures that are different from nursing home measures, and a few that are consistently measured across the four post-acute care provider groups. A review of several select CMS indicators across the five states is noted below. For each of these measures, the higher the score indicates better performance. There is not much variation here among states.

![2017 Select CMS Home Health Ratings for Five Peer States](image)

*Home Health Compare, May 2019*
Discussion and Summary

In looking at the drivers for LTSS reform, it is often about cost, access to home and community based services, and quality. Quality in nursing home care has been the focus of many of the federal initiatives over the past two decades. Quality in home health care and home and community based services, while an issue less published, is also of concern especially since these consumers are very vulnerable and often isolated. Quality in assisted living – has also a concern over the past several years as identified through many media sources. If LTSS programs are not delivering a certain level of performance, access and cost are less meaningful issues. After years of monitoring quality for LTSS, we find:

- A lack of a performance system that can measure outcomes across the entire system
- An ever increasing level of regulatory burden to address quality in nursing homes that may be driving resources away from patient care
- Significant variation in nursing home performance across Michigan

LeadingAge Michigan Quality Recommendations:

- Transparency in data across all LTSS programs; development of an annually published report that identify quality challenges, outcomes, spending for programs and any integrated models
- Elevating and escalating the conversation about the efficiency and efficacy of the survey and certification process at state and federal levels – without undermining the capability of the state to deal with low-performing providers
- Review of LeadingAge’s *Broken and Beyond Repair* Report to update issues that cause burden to high performing providers
- Increase timing between annual visits for high performing providers
- Use of focused random visits for facilities who are trending poorly, using LTC ombudsman if necessary
- Use of a LTC Ombudsman across all venues
- Improved reporting methods for facility reported incidents that include all the necessary information about follow up actions to the incident and any necessary reporting to public enforcement agencies to help prioritize need for on-site visits
- Use of performance trends over time to address poor performers who move in and out of significant compliance problems in consistent SQOC areas
Michigan LTSS and Workforce

For many LTSS providers and consumers, workforce issues top the list of challenges for 2019. High employment rates overall and competition for employees has made filling these critical positions only more difficult.

Direct care workers assist consumers with disabilities through personal care and often home duties such as shopping, laundry, and meal assistance for those in the community. Currently, although there are differing qualifications for certain positions, direct care workers serve as assistants in the Home Health Program, nursing homes, and as private care aides.

Nursing Homes and Nursing Assistants

More than 600,000 nursing assistants provide care to seniors and adults with disabilities in nursing homes across the United States (PHI, N.D.). In contrast to home care, where services are often intermittent, assistants in nursing homes generally experience 8-hour shifts of repeated lifting and moving. In general, because consumers in nursing homes require more care, these positions are often considered more difficult. Nursing assistants on average are 3.4 times more likely to become injured than the average worker. When recruitment and retention issues are direct challenges to a given nursing facility, often workloads and pressures only increase for the direct care worker.

Because nursing assistants are the front-line workers in facilities, they represent more than a third of the overall nursing home workforce. They are also in a critical position to observe residents directly and help nursing staff address issues as they arise. Therefore training is essential. Each state has its own requirements for nursing assistant training and certification. In Michigan, nursing assistants must complete a defined 75-hour training program and pass the certification test. On-boarding and mentoring new employees is the responsibility of nursing homes, which sometimes is lacking. Because of poor staffing at times, some facilities place nursing assistants in independent roles before they may be fully oriented.

Wages for nursing assistants, while slightly higher than home care workers, averaged about $12.34 per hour in 2016, and 53% are employed only part-time (PHI, N.D.). Many carry two part-time jobs that might include 3-4 shifts per week each. While nursing facility workers are more likely to receive some health insurance benefits, 14% have no health insurance at all – a decrease from 28% before the Affordable Care Act changed the requirements for health care coverage. See the chart below.
As discussed earlier in this report, the population of older seniors will grow through 2050. Persons 85 and older, the age where nursing home use starts to peak, will triple between now and 2050 to 19 million nationally. In addition, the number of persons nationwide and in Michigan age 18-64 is expected to remain flat — this is the population that workers are drawn from which means there will be fewer potential caregivers per aging senior.

In the absence of federal policy and support, many states have developed programs and initiatives that are intended to strengthen and support recruitment, retention, and training.

**Home Care and Personal Care Workers**

Recruiting staff for home care positions has also become more difficult. These are also often considered poor quality jobs, wages are low — even lower than for nursing home assistants — and access to benefits even more challenging. While home health aides (working with skilled nursing for patients generally recovering at home) may perform some medical-related tasks under supervision, home care workers generally spend their time assisting with personal care (bathing, grooming, eating) and light home duties such as shopping and laundry.

Like nursing assistants, despite great demand for workers, wages have remained flat over the past decade. Many work only part time and are less likely to receive benefits than nursing home employees. Some home care staff may have received some training, but there are no requirements — although there are generally training requirements for home health aides. Both the uninsured rate and use of public assistance is higher for home care workers than for nursing assistants.

The Michigan Aging and Adult Service Agency projects that currently there are 171,490 direct care workers in Michigan and an additional 24,000 will be needed by 2022. That agency has supported and participated in several initiatives to address the caregiver shortage in Michigan. Direct care workers are the very center of the LTSS delivery system, and Michigan like other
states is nearing that crisis point where there are not enough workers to serve our senior population. The Michigan working-age population is decreasing proportionally to the aging population. Michigan ranked 29th in Family Caregiver Burden which ultimately impacts reliance on paid caregivers. Stagnant wage levels for Michigan direct care workers are identified in the chart below.

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**Discussion and Summary**

Future demand for home care workers and nursing assistants is hard to predict. Changes in utilization of nursing homes in the future may further shift higher demand to home care needs. However, insufficient numbers of caregivers is likely in the near and distant future, making it even more important to address the challenges to recruitment and retention. Home care workers are expected to be one of the fastest growing occupations.

Direct Care Workers are essential - they are the vital element to ensuring quality long term services and supports. Job satisfaction, consistent assignment, and health insurance are associated with higher retention rates. But developing a program that works to improve both recruitment and retention takes time and effort – but is necessary for the future of senior care in Michigan.

States who have moved to Medicaid Managed Care, including Managed LTSS, often have experienced more constraints on direct care giver wages. Increases in labor costs have placed increasing pressures on some agencies who staff home care workers. Prior to ACA expansion of coverage, direct care workers faced even more barriers to health care coverage. Direct caregivers also in general have a disproportionate number of pre-existing conditions that impact their ability to gain access to health care.
State action will be needed to address the critical shortage of direct care givers. The 2006 Better Jobs/Better Care Initiative between LeadingAge and PHI identified elements of Quality Caregiver Jobs: family sustaining wages, family supportive benefits, full time options and balanced workload, training that helps workers develop and hone relational and technical skills, career advancement opportunities, supervisors who set clear expectations while providing encouragement and support, and owners and managers will to lead participative and ongoing quality improvement.

It’s clear that direct caregivers need to be able to grow and develop within their job and taking time to recruit the right individual is critical. This year, Michigan is again looking at developing and certifying a new category of staff called a Medication Technician. We anticipate this initiative could assist with both nurse staffing issues and a career ladder for CNAs.

The path to a sufficient and trained workforce across the industry is challenged by a number of issues:

1. **Part-Time Work**: Many workers live in or on the verge of poverty as they struggle with low and stagnant wages, coupled with part-time hours. Workers need both a living wage and sufficient hours to support themselves and family. About 30% of all direct care workers are engaged part-time – often because part-time employment is all that is available. Some work part-time because of home responsibilities, and many hold more than one part-time direct care position. These issues unfortunately cause a large number of workers to depend on public benefits. Many employers only hire part-time workers to avoid paying benefits.

2. **Low Wages**: Hourly wages for home care workers hover around $10.00 per hour on average, a rate that has remained virtually flat for the past decade when adjusted for inflation. Twenty-three percent of home care worker households live below the federal poverty level. Nursing assistants, while receiving slightly higher wages, also struggle with poverty.
3. **Reliance on Public Benefits**: As of 2018, 39% of nursing assistants (working in nursing homes) and 52% of home care workers receive public support of some sort. Many must rely on Medicaid for health care since they do not receive employer-based health insurance. PHI National estimates that 26% of home care workers have no health care coverage.

4. **High Turnover Rates**: Difficult work, low wages, inadequate benefits, and often erratic schedules contribute to rapid turnover rates, and movement from one job to another— or movement out of the field altogether. Additionally, although culture change in nursing homes and other programs have improved the employee-employer relationship in many instances, management practices often impacts retention as well.

5. **High Injury Rates**: The strenuous work of direct caregiving makes nursing home staff three times as likely as other direct care workers to be injured on the job.

6. **Impact on Families**: When home care workers cannot be found, families may find themselves quitting a job or placing a loved one in a nursing home.

7. **Work Setting**: A highly regulated environment, poor industry image, limited training and mentoring, often in a setting with hierarchical and top-down communication and limited supervision.

**LeadingAge Michigan Workforce Recommendations**

To prepare for LTSS in the 21st century, it is important that Michigan form a vision for training and support to formal and informal caregivers. Specific initiatives must be developed to identify programs that will strengthen and support recruitment, retention, training, and mentoring.

- Michigan support for initiatives that will review the breadth and depth of issues and validate what truly drives recruitment and retention issues across the industry
- Protection of expanded Medicaid benefits and tax credits that allow direct care workers to obtain health insurance coverage
- Revision to CNA Michigan training programs and onboarding requirements
- Funding for successful training models, standards, and curricula for aides, through grants
- Pilot training programs for certain conditions such as diabetes and Alzheimer’s
- Processes to gather better data to measure Michigan workforce volume, stability, compensation, turnover, vacancy rates, wages, and benefits
- Consideration to use an Abuse Registry to identify CNA staff with a history of abuse, with confining criminal charges to persons who intentionally are abusive to seniors
- Promotion of improved performance by managed care plans ensuring adequate rates, quality strategies, performance measures, improvement projects, and mechanisms to identify enrollees with high needs
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Appendix I - Access and Utilization/MDHHS Appropriations

**Michigan Home Help Budgeted Funding**

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**Medicaid Home Health Budgeted Funding**

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Medicaid Hospice Budgeted Funding

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Personal Care Services - Adult Foster Care Budgeted Funds

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There was no individual line item for PACE funding for FY 2016. It appears it was included with LTSS Integrated Care Budget.

![PACE Budgeted Funding](chart)

![MI Choice Budgeted Funding](chart)
Appendix II – Acronyms

- AARP: American Association of Retired Persons
- AASA: Michigan Aging and Adult Services Agency
- CHRT: Center for Health Research and Transformation
- CMS: Center for Medicare and Medicaid Services
- CNSA: Certified Nursing Assistant
- FFS: Fee-for-Service - Reimbursement mechanism
- HCBS: Home and Community Based Services
- LTSS: Long Term Services and Supports, sometimes used interchangeably with LTC, Long Term Care
- MDHHS: Michigan Department of Health and Human Services
- (M)LARA: Michigan Department of Licensing and Regulatory Affairs
- MI Choice: Michigan’s 1915(c) program for elderly and disabled
- MI Health Link: Michigan’s Demonstration Project to Integrate Care for Persons with Medicare and Medicaid
- NFLOC: Nursing Facility Level of Care
- PACE: Program of All Inclusive Care of the Elderly
- RTI: Research Triangle Institute – entity that evaluates certain CMS demonstrations
- SQOC: Substandard Quality of Care – in reference to nursing home deficiencies
- 1915(c)/1915(i) – Sections of the Social Security Act