Consumer-Focused, Cost Effective Long Term Care for an Age-Friendly Michigan

A White Paper for Michigan Policymakers

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Executive Summary

AARP believes, and the public agrees, that Americans who need long term care should have access to affordable and quality services in the setting of their preference. A system that starts with the individual and addresses medical, housing and mobility needs, helps people stay in their homes and communities, and helps prevent the unnecessary use of more costly institutions. A comprehensive person-centered long term care system will serve the needs of individuals and their families, and provide efficiencies in public spending.

This white paper is intended to provide information to Michigan policymakers as you make policy and funding decisions regarding the design and delivery of long term care services in Michigan, and more broadly, in your efforts to create a more vibrant, age-friendly Michigan. The data, research and AARP's policy recommendations in this paper can be summarized as follows:

- The overwhelming majority of Michigan voters want to avoid ever living in a nursing home. If or when they need long term care services, they prefer to stay at home, or in a home-like, community setting.

- Nursing homes are expensive, and becoming more expensive. Total Medicaid expenditures for nursing home care in Michigan grew 4% in FY 2009 and 8.2% in FY 2010. In 2011, the median annual rate for a semi-private room in a nursing home in Michigan was $80,300.

- An array of lower cost alternatives to nursing home care exists for people who need long term care services, and other states make those alternatives more available for their residents than Michigan does. Thirty-five states spend a smaller proportion of their long term care dollars on nursing homes than we do in Michigan.

- The State of Michigan can save money by rebalancing our long term care system in the direction that Michigan residents overwhelmingly favor. A national analysis published in 2011 found that the use of home and community based services (HCBS) produced an average annual public expenditure saving of $57,338 per participant. On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in HCBS for every one person in a nursing home.

- Family caregivers are the backbone of Michigan's long term care system. Providing better and more meaningful supports for family caregivers is essential to the well-being of Michigan's long term care system, our economy, our communities and our families.

- It's time to recognize new opportunities for an age-friendly Michigan.

At this juncture in our state's history, it is important not only that Michigan succeed in the design and delivery of our long term care system, but also that we embrace the opportunity to transcend this singular issue to create a more vibrant, age-friendly Michigan. AARP looks forward to working together with the Michigan Legislature and Governor Rick Snyder's administration to achieve this great vision for our great state.

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for an Age-Friendly Michigan
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Introduction

AARP believes, and the public agrees, that Americans who need long term care should have access to affordable and quality supports and services in the setting of their preference. A system that starts with the individual and addresses medical, housing and mobility needs, helps people stay in their homes and communities, and helps prevent the unnecessary use of more costly institutions.

Perhaps more importantly for Michigan policymakers and taxpayers, a comprehensive, person-centered, long term care system will not only serve the needs of individuals and their families, *but also* provide efficiencies in public spending.

The following guiding principles for the design and delivery of systems of long term care – also referred to as long term services and supports (LTSS) – were developed by AARP and are set forth in greater detail in *The Policy Book: AARP Public Policies 2011–2012*, which is available in hardcopy or at www.aarp.org/policybook.

- The design and delivery of long term care services should promote consumer independence, choice, dignity, autonomy, and privacy.
- Long term care programs and services should be easy to access and affordable.
- People who qualify for Medicaid should have a choice between home- and community-based care or nursing home care, and a choice of providers.
- The federal and state governments must ensure the delivery of high-quality long term care services.
- Provider payments should be adequate.
- Public long term care services programs should include cost-containment mechanisms.
- The rights of long term care consumers should be protected.
- Services should include in-home assistance, community services, a full range of supportive housing options, institutional care, rehabilitative services and other enabling services, as well as assistive devices and home modifications.
- Long term care systems should give meaningful support to family caregivers.

What Michigan Residents Want

Most people who need long term care services strongly prefer to remain in their homes. When they need or want to move to receive services, people strongly favor assisted living residences or other home-like settings over nursing facilities. Most consumers, regardless of age

or disability, want to direct how they receive long-term care services in order to maintain their dignity and maximize their independence.

This is nothing new. In an extensive survey conducted in 2005 of Michigan voters age 45 and older, respondents nearly universally reported that it is very (83%) or somewhat (12%) important to them that long-term care services be available to enable them and family members to remain in their own homes as long as possible should they need long-term care services. Of the one in five (21%) respondents who reported that they had a friend or relative in a nursing home at the time they participated in the survey, nearly two in five (37%) indicated that the person would return to his or her home or community if home care and support services were both available and affordable.[1] This Michigan data is consistent with the national data that AARP has continued to collect since then.

Despite the large increase projected in the coming years for Michigan's senior population, the demand for institutional services is predicted to grow very slowly. Despite large increases in the older population from 2000 to 2007, the number of people in nursing homes in the United States remained about the same, at 1.44 million.[2]

Michigan residents don't want to live in nursing homes if they can avoid it. They prefer to stay in their own homes if possible, or in a home-like setting.

As our population ages, the increase in demand for long term care services in Michigan will not be an increase in demand for nursing home beds. The increase in demand will be for home and community based services that allow Michigan residents to continue living in their current homes, or in other home-like settings.

Already there is evidence of this trend, with long waiting lists for home care in Michigan, while thousands of nursing home beds lie empty. In 2010, Michigan had a 16% vacancy rate for nursing home beds, which equated to about 7,210 empty nursing home beds in our state.[3] At the same time, the Michigan Department of Community Health noted in April 2011 that "only 7,239 individuals are served through MI Choice, Michigan's home and community based (HCBS) waiver for individuals who are elderly or have a disability. With a waiting list of 7,900 individuals, more people are awaiting waiver assistance than are being served by MI Choice.[4]

Current Long Term Care Funding and Financing

The major source of public long term care funding is the joint federal and state Medicaid program, which pays for nursing home care and a limited amount of home and community based services. Nationally, long term care services of all types accounted for 34.5% of total Medicaid expenditures in FY 2009, and have accounted for 34-36% of total Medicaid spending since FY 2005. In Michigan, long term care services of all types accounted for 33% of total Medicaid expenditures in FY 2009, and accounted for 28.7-32.2% of total Medicaid spending from 2005 through 2008.[5] Medicaid has stringent financial eligibility criteria. Individuals do not qualify

financially for Medicaid unless they have extremely low assets and income, or have spent almost all of their assets and income to pay for their health care and long term care services.

In Michigan, long term care accounted for 33% of total Medicaid expenditures in FY 2009.

The Medicare program provides a lesser amount of funding for long term care through limited coverage of short stays for rehabilitative care in nursing homes, and some home health care services. Medicare, which paid for about 22% of long term care expenditures in 2008, funds medically necessary home health care, but beneficiaries must be "homebound" and need skilled health care in order to receive the benefit. Medicare also pays for a limited amount of skilled rehabilitative nursing home care for beneficiaries with physician orders for skilled care who have had a prior hospital stay of at least three days. [6]

Smaller public programs that provide long term care funding include the U.S. Department of Veterans Affairs program, the Social Services Block Grant program, and Title III of the Older Americans Act. Each of these programs has its own eligibility criteria and covers only a limited amount of long term care services.

The majority of long term care services are provided by unpaid family members and friends. In Michigan, an estimated 1 out of every 7 adults is currently serving as a caregiver for an adult family member. In 2009, about 42.1 million family caregivers in the United States provided care to an adult with limitations in daily activities at any given point in time, and about 61.6 million provided care at some time during the year. These unpaid services had an estimated economic value in the United States of $450 billion in 2009 (up from an estimated $375 billion in 2007), which exceeds the value of all *paid* long term care services. To put this number in perspective, $450 billion is more than the nation's total Medicaid spending in 2009, including both federal and state contributions for both health care and long term care services. In Michigan, the estimated value of unpaid caregiver services in 2009 was $15.5 billion.[7]

Comparing Costs

According to the 2011 Cost of Care Survey conducted by Genworth Financial, the cost of long term care services provided by nursing homes has steadily increased over the eight years the annual survey has been conducted. From 2005 to 2011, this increase represents a 4.35% compound annual growth rate. In contrast, rates charged by home care providers for "non-skilled" services have remained relatively flat.[8]

Not surprisingly, Medicaid expenditures in Michigan for nursing home care are escalating. Total Medicaid expenditures for nursing home care in Michigan grew 4% in FY 2009 and 8.2% in FY 2010.[9]

According to Genworth, the median daily rate in Michigan for a nursing home in 2011 was $235 for a private room (median annual rate of $85,775) and $220 for a semi-private room (median annual rate of $80,300). The median annual cost for a private one-bedroom unit in an assisted living setting was $36,000, or $3,000 per month.[10] The median annual cost of receiving 30 hours a week of home care in Michigan in 2011 was $29,453.[11]

Nursing homes are expensive, and becoming more expensive.

According to a 2011 Thomson Reuters analysis of Michigan's spending on long term care services in 2009, Michigan spent $1.547 billion on nursing home services, compared to a combined total of $426 million for home and community based services for older adults and people with physical disabilities. That means the percentage of total public dollars spent on non-institutional long term care services for older adults and people with physical disabilities in Michigan was only 21.6%, compared to 78.4% that was spent on nursing home services. That analysis compared Michigan with all other states and found that 35 states spend a smaller proportion of their long term care dollars on nursing homes than we do in Michigan, many of them quite significantly.[12]

Meeting Consumer Demand While Saving Taxpayer Dollars

The State of Michigan can save taxpayer dollars by rebalancing our delivery of long term care services in the direction that Michigan residents overwhelmingly favor: Michigan can save money by shifting how the state delivers long term care services away from unnecessary institutionalization and toward the delivery of more long term care services in people's homes or other home-like settings in the community. "Balancing" or "rebalancing" means ensuring that people with long term care needs have access to a variety of services to meet their needs and their preferences for assistance, and are not just sent to nursing homes.

Multiple studies have shown that states that provide a higher proportion of the long term care their residents need through home and community services save money. A 2009 study by the Institute for Health and Aging at the University of California, San Francisco, examined the long term care spending by all states from 1995-2005, and found that states with more extensive home and community based services programs experienced slower total spending growth for long term care than those states that offered only limited home and community based services.[13]

A national analysis published in 2006 compared the costs in 2002 of providing home and community based services under the Medicaid 1915c waiver (which requires participants to have an institutional level of care need) versus providing Medicaid institutional care. That analysis found that the use of HCBS produced an average annual public expenditure saving of $43,947 per participant.[14] A similar analysis published in 2011 that examined cost data from 2006 found that the use of HCBS that year produced an average annual public expenditure saving of $57,338 per participant.[15]

Increased Federal Funding for State Rebalancing

For both nursing home and HCBS costs, the federal government provides Medicaid funding that covers a majority share of those costs. For FY 2012, Michigan's federal match for both types of services is 66.14%. In FY 2013, Michigan's federal match rate will be 66.39%.

Opportunities currently exist for Michigan to obtain a federal funding rate up to 6% higher by expanding access to home and community based care. As part of the Patient Protection and Affordable Care Act of 2010, Congress established new financial initiatives to facilitate states' expansion of their home and community based services programs:

- The State Balancing Incentive Payments Program (BIPP) is a temporary, non-competitive grant program designed to encourage states to balance their Medicaid spending toward HCBS. Qualifying states agree to allocate 50% of their total Medicaid long term care dollars toward non-institutional services by October 1, 2015. States must submit a work plan to develop a single point of entry (SPE) system, a conflict-free case management system, and a core standardized assessment instrument. If Michigan chose to participate in BIPP, our federal matching rate would increase by 2% from now through October 2015. A recent analysis by Health Management Associates estimated that Michigan could realize savings in excess of $45 million by utilizing BIPP (based on the period October 1, 2011- September 30, 2015).

Michigan can save taxpayer dollars by rebalancing our delivery of long term care services toward what Michigan residents overwhelmingly want.

- The Community First Choice Option (CFCO) program allows states to expand home and community based services under Medicaid Section 1915k to add a new participant-directed HCBS attendant services benefit. This option can serve individuals with incomes above 150% of the federal poverty guidelines, up to 300% of SSI, who meet Medicaid's "institutional level of care" eligibility requirements, and it can serve Medicaid eligible individuals with incomes up to 150% of the federal poverty guideline who do not need an "institutional" level of care. If Michigan chose to participate in CFCO, we would receive a permanent federal match increase of 6% over our normal rate for the HCBS services we offer through this program.

As are described in greater detail below, the requirements for these federal programs that incentivize balancing by states of their long term care services reflect in large part the very recommendations already made for Michigan in the *Final Report of the Michigan Medicaid Long-Term Care Task Force (2005).*

Stepping Back a Few Years: We've Had This Debate Before

In 1999, the United States Supreme Court issued its landmark ruling in *Olmstead v. L.C.*[16] that state governments may not operate programs in a way that unnecessarily forces people with disabilities to live in nursing homes. Following that ruling, a related lawsuit known as *Eager v. Engler* (which later became *Eager v. Granholm*) was filed in Michigan. *Eager v. Granholm* was settled in 2004, and one of the requirements of that settlement was the establishment of a 21-member bipartisan task force to assist the State of Michigan in developing options for expanding the availability of home and community based services, and for improving long term care services.

Over a ten-month period in 2004, Michigan's Medicaid Long-Term Care Task Force engaged with over 200 consumers and professionals across eight workgroups, representing the full array of services and constituencies. In the spring of 2005 the task force produced a comprehensive set of recommendations that were adopted by consensus and set forth in *Modernizing Michigan Medicaid Long-Term Care: Toward an Integrated System of Services and Supports.*[17] This document is also referred to as the *Final Report of the Michigan Medicaid Long-Term Care Task Force.*

From 2005 through 2009, Michigan engaged in initial implementation efforts of key recommendations from the *Final Report of the Michigan Medicaid Long-Term Care Task Force,* including the piloting of four regional "Single Point of Entry" agencies for consumers. An analysis performed in 2009 by Health Management Associates regarding the cost effectiveness of Michigan's initial Single Point of Entry (SPE) efforts indicated promising trends during their short existence.[18] Unfortunately, Michigan's SPE pilots were eliminated in 2009 as part of the extensive state budget cuts set forth in Executive Order 2009-22.

More recently, the Health Care Association of Michigan (HCAM), a trade association of the state's for-profit nursing facilities, in 2011 presented to the Michigan Legislature a paper it commissioned for preparation by Public Sector Consultants, entitled *Michigan Skilled Nursing Facilities, the Minimum Data Set, and the MiChoice Waiver Program: An Analysis and Implications for Policy* (May 2011). That paper attempted to support a number of assertions regarding the current state of long term care service delivery in Michigan, and proposed in particular to answer the question "whether significant numbers of skilled nursing facility residents could or should be transitioned to home or other community-based care, either because this would provide a lower cost to Medicaid or for other reasons." HCAM's analysis concluded that Michigan's nursing homes are currently doing an effective job of ensuring that only those persons who need to remain in a nursing home are continuing to stay in nursing homes.

HCAM's paper has been criticized by aging and disability advocates across the state, particularly those involved with Michigan's Olmstead Coalition and who participated on the *Michigan Medicaid Long-Term Care Task Force*. In February 2012, an official response entitled *"Assessing the Success and Critical Importance of the MI Choice and Nursing Facility Transition Supports and Services Programs: A Response from Aging and Disability Advocates to*

the HCAM/Public Sector Consultants' May 2011 Analysis of MI Choice" found significant fault with eight of the key assertions made in HCAM's May 2011 paper. AARP Michigan is in agreement with the points made by our fellow aging and disability advocates in their February 2012 response to HCAM's 2011 paper.

Michigan's long term care system is currently ranked #31 in the nation according to *Raising Expectations (2011), A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*.[19] Our current system of long term care has positive aspects, but there is clearly room for improvement. The increasing demand for home and community based services in Michigan can be seen as evidence that the consumer market wants a different product: services delivered in Michiganders' own homes and communities, rather than in facilities. As part of Michigan's move toward becoming more age-friendly, a practical response from nursing home care providers may be to continue to expand their own portfolios of community based service offerings to better meet market demands.

What Success Looks Like

In 2007, 12.7% of Michigan's population was age 65 or older. By 2030, 19.5% of Michigan's population is expected to be 65 or older, and 9.3% of Michigan's population is expected to be 75 or older.[20]

By 2030, 19.5% of Michigan's population is expected to be 65 or older.

As Michigan residents grow older, certain features of communities become more important. One aspect of an age-friendly Michigan is the availability of long term care services that are coordinated, affordable and high-quality, that offer consumer choice, and that provide support for family caregivers. In this regard, there is no need to reinvent the wheel. States that have achieved greater success in transforming their long term care systems to give people choice and reduce their reliance on nursing homes share certain characteristics.[21] They include:

- *Philosophy* – The state's intention to deliver long term care services in the most independent living situation and to expand cost-effective HCBS options guides all other decisions. How a state views quality of life for older adults and people with disabilities, and the importance of participants having a choice in how their services are provided, may be the most important factor in having a balanced long term care system.
- *Array of services* – States that provide a comprehensive array of services designed to meet the particular needs of individuals and to address the needs of people of all income levels are less likely to channel people to institutions than states providing few options.
- *Organization of responsibilities* – Assigning responsibility for overseeing the state's long term care system to a single administrative office, agency or department is a key decision in some of the most successful states.
- *Single entry point* – A considerable body of literature demonstrates the value of having an

independent, conflict-free, single point of entry for people to use to access long term care services. Effective systems that determine eligibility, coordinate services, and monitor quality can support people who have their own resources to pay for services, as well as those who qualify for public programs. A robust system of information, options counseling, and assistance is key.

- *Single appropriation* – This concept, sometimes called "global budgeting," allows states to transfer funds among programs and, therefore, make more timely decisions to facilitate serving people in their preferred setting.
- *Timely eligibility* – Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, state Medicaid programs must be able to arrange for HCBS in a timely manner. Failure to determine timely eligibility for Medicaid HCBS often results in unnecessary nursing home placement. Successful states have implemented procedures that either presume financial eligibility for Medicaid HCBS or fast-track the eligibility determination process.
- *Standardized assessment tool* – Some states use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. A standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization, and can be used to collect consistent data, leading to better system management.
- *Participant direction* – The growing movement to allow individuals a greater role in determining who will provide them with services, as well as when and how services are delivered, responds to the desire of all people to maximize their choices and control over their lives.
- *Qualified workforce* – A successful state program supports the development of a knowledgeable, culturally competent, highly valued, and competitively compensated long term care workforce.
- *Recognition and support for family caregivers* – Family caregivers are the backbone of the long term care services system and key partners in health care. Person- and family-centered care calls for addressing family needs and integrating family caregivers as partners in care. Providing better and more meaningful supports for family caregivers is essential to the well-being of our long term care system, our health care system, our economy, our workplaces, and our families.[22]

New Opportunities for an Age-Friendly Michigan

While health care and long term care services are important, long term care is not all we need to create an age-friendly Michigan.

In 2006, the World Health Organization brought together 33 cities in 22 countries to help determine the key elements of communities that support active and healthy aging. The result was *A Guide for Global Age-Friendly Cities and Communities,*[23] which outlines a framework for assessing the "age-friendliness" of a city or community. In an age-friendly community, policies, services, settings and structures support and enable people to age actively by:

- recognizing the wide range of capacities and resources among older people;
- anticipating and responding flexibly to aging-related needs and preferences;
- respecting individuals' decisions and lifestyle choices;
- protecting those who are most vulnerable; and
- promoting seniors' inclusion in, and contribution to, all areas of community life.

The availability of health care and appropriate long term care services that promote consumer independence, choice, dignity, and health and well-being is one essential pillar of an age-friendly community as identified by the World Health Organization. The others are safe and affordable transportation; the availability of outdoor spaces such as parks and other recreational facilities; a wide range of housing options; social participation, inclusion, and multigenerational interaction; paid work and volunteer opportunities; and access to information and communications technology. An "age-friendly" community emphasizes enablement rather than disability; it is friendly for all ages rather than just "elder-friendly."

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Other new ideas continue to emerge and present additional innovative opportunities for people to stay in their communities and "age in place." One such idea now being explored in Michigan is the concept of a "Village," a model for aging in place in which neighborhood residents organize themselves to help coordinate and deliver services and supports within their community. AARP Michigan recently entered into a partnership with the Northwest Initiative, a local nonprofit organization, to explore developing a Village among residents in the northwest part of Lansing.[24]

A Call to Action for Michigan Policymakers

Michigan policymakers have debated the issue of long term care before. There is ample research and data to show what has worked in the past and what has not, how much things cost, and where new opportunities may lie. As our population ages, Michigan will continue to have a need for nursing homes. However, the way for policymakers to plan for the aging of Michigan's population is not to try to figure out how to pay for more nursing home care. Instead, Michigan policymakers should plan for an age-friendly Michigan in which the types of services that our residents will need can be delivered in a cost effective way that provides choices for individuals and their families.

AARP respectfully submits to Governor Snyder and the Michigan Legislature that the policy recommendations set forth back in 2005 in the bipartisan *Final Report of the Michigan Medicaid Long-Term Care Task Force* still hold promise for our state. Additionally, in the years

since then, AARP and other organizations have continued to study and gather best practices regarding these issues at the state, national, and global level.

At this juncture in our state's history, it is important not only that Michigan succeed in the design and delivery of our long term care system, but also that we embrace the opportunity to transcend this singular issue to create a more vibrant, age-friendly Michigan. AARP looks forward to working together with the Michigan Legislature and Governor Rick Snyder's administration to achieve this great vision for our great state.

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