Michigan Department of Community Health

MDCH

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MICHIGAN

PROFILE OF PUBLICLY-FUNDED LONG-TERM CARE SERVICES

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PREPARED AND SUBMITTED BY:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES

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Profile of Michigan:
ASSESSMENT OF MICHIGAN'S LONG-TERM CARE SYSTEM

Forward

The State of Michigan is in an exciting period of reform to its system of long-term care supports and services (LTCSS). Along with the national trend, consumers of LTCSS and advocates have demanded their right to receive those LTCSS where and how they prefer, largely in their own homes and community or in chosen congregate settings that have private, home-like environments, and social activities.

Since the mid-1990s, Michigan has made several attempts to reform its LTCSS system. These efforts resulted in incremental steps toward significant systems change. In the early new millennium several factors converged[1] and Michigan began a process of meaningful LTCSS reform.

As Michigan continues to rebalance its LTCSS system, it is important to assess progress. Michigan received one of 10 State Profile Grants from the Centers for Medicare and Medicaid Services (CMS) to develop a profile of publicly-funded long-term care and to assist CMS in developing national benchmarks for all states to use to assess their progress in rebalancing.

MICHIGAN'S LONG-TERM CARE, SUPPORTS AND SERVICES PROFILE CAN:

- PROVIDE A SNAPSHOT OF THE LONG-TERM CARE SUPPORT SYSTEM, TO ENSURE A COMMON KNOWLEDGE BASE AMONG POLICYMAKERS AND STAKEHOLDERS;
- IDENTIFY OPPORTUNITIES FOR IMPROVED COORDINATION AND COLLABORATION;
- ACKNOWLEDGE THE SUCCESS THAT HAS OCCURRED;
- IDENTIFY SERVICE GAPS;
- PROVIDE RECOMMENDATIONS FOR IMPROVEMENT; AND
- PROVIDE A FRAMEWORK FOR COMPARING REBALANCING EFFORTS ACROSS THE STATES.

The Department of Community Health (DCH), Office of Long-term Care Supports and Services (OLTCSS) contracted with the Michigan Public Health Institute to develop a profile of the state's long-term care system. The OLTCSS subsequently contracted with key stakeholders to further develop the content and framing of the profile.

The profile represents an analysis of Michigan's publicly-funded long-term care system. The information provided encompasses a variety of state and federal resources, multiple programs across several state departments, and multiple populations. It was collected through interviews with many Michigan government employees, advocates, and stakeholders involved in the system. The profile report represents a partnership of involvement with the OLTCSS and a

[1] These factors included:
- The Court settlement of the Eager vs. Engler/Granholm "Olmstead"-type lawsuit.
- The establishment of the Medicaid Long-Term Care Task Force and their nine strategic recommendations.
- Executive Order 2005-14 establishing single point of entry demonstration projects, the Office of LTC Supports and Services, and a permanent LTC Supports and Services Advisory Commission

Stakeholder Advisory Council, a 20-member body comprised of consumers, caregivers, stakeholders, advocates and government employees. This culturally and geographically diverse group includes representatives from dementia, aging, mental health, single point of entry demonstration project agencies, area agencies on aging, persons with disabilities, direct care workforce, and elder law.

Organization of the Profile

Section 1 begins with a background section that focuses on political and historical factors that have shaped Michigan's LTCSS system and its reform efforts:

1. demographic indicators of long-term care demand,
2. traditional service utilization patterns, and
3. the support system's unique historical and political characteristics.

Section 2 provides an overview of state and local long-term care administration and important infrastructure and capacity needs for effective LTCSS. This section introduces the government agencies responsible for publicly-funded care, supports and services, and describes the roles the legislature, administration, consumers and families have typically played in systems change.

The bulk of this report describes the long-term support delivery systems for the following major population groups:

- older adults and people with physical disabilities,
- people with developmental disabilities,
- people with mental illness,
- children, and
- other people within populations who have LTCSS needs such as:
  - people with dementia,
  - people with substance abuse problems,
  - people in Native American tribes and off-reservation,
  - veterans, and
  - people exiting correctional facilities.

Information is presented describing key system components for each population group.

Key System Components

- **Consolidated state agencies** – Michigan has established the OLTCSS within the DCH to serve as the focal point for long-term care systems reform efforts. The OLTCSS works closely with other state agencies[2] to coordinate effort and reduce existing fragmentation of long-term care services across the various state agencies.
- **Single access points** – Michigan funded four single points of entry (SPE) agencies on a demonstration basis to provide information and assistance and options counseling to Michigan citizens seeking LTC services. These demonstration projects were eliminated effective June 1, 2009 by Executive Order 2009-22 due to severe and continuing budget constraints. Their elimination was based on lack of funding not performance, and there remains widespread support among advocates and stakeholders for an unbiased single point of entry.
- **Institutional supply controls –** Michigan has Certificate of Need provisions that enable it to limit or reduce institutional beds.
- **Transition from institutions –** Michigan has implemented access to nursing facility transition services statewide through MI Choice waiver agents and Centers for Independent Living. Michigan's one remaining state ICF/MR, which is slated to close in FY 2010, plans to transition as many individuals as possible to community environments.
- **A continuum of residential options –** Michigan is currently working to enable MI Choice services in licensed living settings such as adult foster care and homes for the aged.
- **HCBS infrastructure development –** Michigan has ongoing, capacity-building activities in several areas of infrastructure development including workforce, single points of entry, nursing facility transitions, and self-determination.
- **Participant direction –** Self-direction, called self-determination in Michigan, is available as an option within both the MI Choice waiver program and the 1915(c) developmental disabilities waiver. Participant direction is being implemented within Older Americans Act and Older Michiganians Act funded programs for the elderly.
- **Quality management –** Michigan has a continually developing system that: a) measures whether the system achieves desired outcomes and meets program requirements, and b) identifies strategies for improvement.

[2]Includes DCH Medical Services Administration, Office of Services to the Aging, Department of Human Services, Department of Corrections, Michigan State Housing Development Authority. Mental health, developmental disability and substance abuse services are coordinated in a separate state bureau.

SECTION 1: BACKGROUND

Each state's long-term support system is shaped by factors that are unique to that state, including its demographic makeup, historical service utilization patterns, and its political and organizational structure. This section describes how each of these factors have helped shape Michigan's long-term care support system.

Demographics

Michigan's demographics are comparable to national numbers. At present, it is the 8th most populous state. However, Michigan is experiencing unprecedented economic issues, with the loss of manufacturing jobs leading to the highest unemployment rate in the nation and the exodus of new college graduates and young families to states with better employment prospects. This leaves behind an aging population and a burgeoning responsibility for providing long-term care supports.

Presently, Michigan is home to a little more than ten million people.[3] The numbers of Michigan residents age 65-74 is projected to increase by 32% by the year 2016.[4]

Table 1-1 Michigan Aging Population Projections, 2008 to 2016

	2008	2009	2010	2011	2012	2013	2014	2015	2016
65-69	380,520	393,977	403,143	413,712	437,769	455,531	475,001	499,390	519,800
70-74	286,777	292,699	296,315	302,859	316,330	333,473	345,293	353,103	362,139
75-79	243,436	238,517	236,666	235,543	235,909	239,409	244,640	247,993	253,830
80-84	195,243	194,290	193,175	191,689	188,609	184,783	181,515	180,727	180,446
85+	193,163	199,119	205,188	210,392	215,191	219,474	222,496	225,643	228,063
All 65+	1,299,139	1,318,602	1,334,491	1,354,195	1,393,808	1,432,670	1,468,945	1,506,856	1,544,278
Total	10,345,033	10,387,724	10,428,683	10,467,470	10,504,167	10,538,487	10,570,208	10,599,122	10,625,075
% 65+	12.56%	12.69%	12.80%	12.94%	13.27%	13.59%	13.90%	14.22%	14.53%

The U.S. Census Bureau estimates that the population of people age 65 and over in Michigan in 2010 will be 1,334,491 or 12.8% of the overall population. That number places Michigan at 32nd (31 states have a higher percentage of people age 65 and older). The percent of people age 65 and over is projected to increase to 19.5% of the total Michigan population by 2030, placing us 20th (19 states have a higher percentage of people age 65 and older). When compared to other states' estimated poverty levels for 2007, Michigan ranked 29th of 50 states with 8.2% of persons aged 65 and over living at or below the federal poverty level.[5]

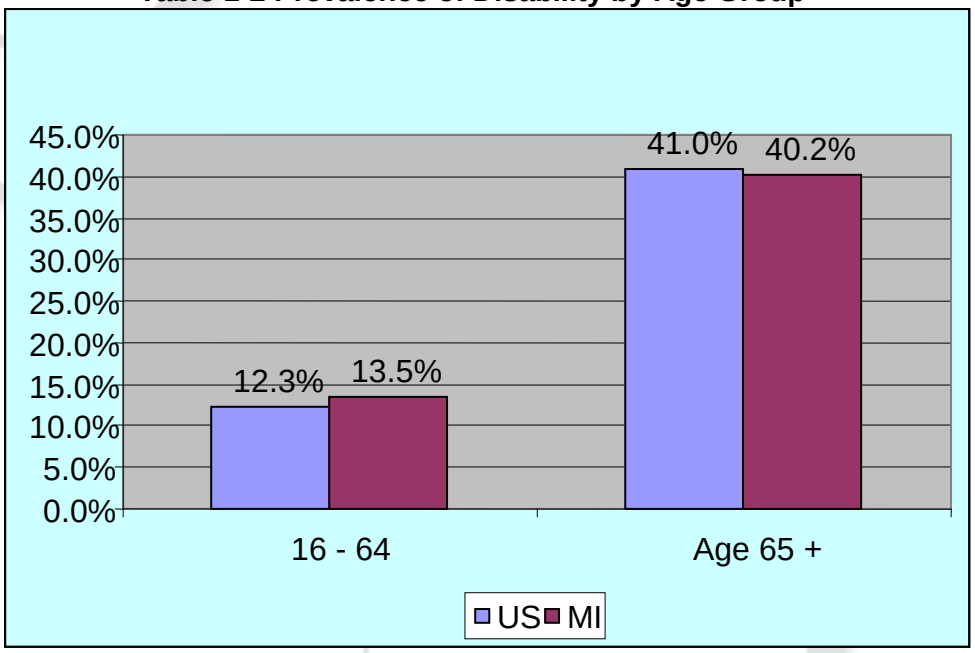
[3] AARP, Public Policy Institute, Across the States: Profiles of Long-Term Care and Independent Living, Executive Summary, State Data, and Rankings. ***http://assets.aarp.org/rgcenter/il/d19105_2008_ats_1.pdf***

[4] U.S. Census Bureau, Interim Population Projections for Five Year Age Groups and Selected Age Groups by Sex for States: July 2004-July 2030. http://www.census.gov/population/www/projections/projectionsagesex.html,

[5] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, POV 46: Poverty Status by State: 2007 http://pubdb3.census.gov/macro/032008/pov/new46_100125_06.htm

The U.S. Census Bureau American Community Survey (non-institutionalized population) indicates that an estimated 13.5% of the population age 16-64 have at least one type of disability while an estimated 40.24% of the age 65 and over population have at least one type of disability.[6] The national estimates are 12.3% for ages 16-64 and 40.95% for age 65 and over. The population of persons with disabilities in Michigan is growing at about the same rate as it is nationally.

Table 1-2 Prevalence of Disability by Age Group



Service Utilization Patterns

In 2007, Michigan spent a slightly smaller proportion of its Medicaid budget for LTC than the national average. However, 82% of the dollars spent were on nursing facility care[7] which is considerably higher than the national average of 73%.

Michigan was ranked the 20th highest in utilization of home and community-based services per 1,000 population in 2005. However, only .9 persons per 1,000 population are receiving services under the elderly and disabled (MI Choice) waiver, ranking Michigan among the lowest (41st) nationally. A significantly higher proportion than nationally (5.5 Michigan, 2.7 US) receive personal care services under the Medicaid state plan.[8]

[6] U.S. Census Bureau, American Community Survey, Sex By Age By Number of Disabilities for the Civilian Non-Institutionalized Population 5 years and Over.
[7] AARP, op. cit., p. 170. Additional note: reported dollars do not take into account "bed tax" dollars which slightly inflates the proportion of LTCSS dollars spent on nursing facilities.
[8] AARP, op. cit., p.171.

Table 1-3 Long-term Care Supports and Services (LTC) Expenditures and Utilization, Michigan and the United States, 2007[9]

	Michigan	U.S.
Proportion of Medicaid Budget Spent on LTC	19.6%	20.6%
Proportion of Medicaid LTC Budget Spent on Nursing Facilities	82%	73%
Per Capita Medicaid Nursing Facility expenditures for older adults and people with physical disabilities	$147	$156
Medicaid Nursing Facility Beds, Per Thousand Persons 65+	38	45
Medicaid per diem nursing facility reimbursement rates	$148	$158
Nursing facility residents per hundred persons 65+	3.3	3.8
Percent of Total Nursing Facility Residents Indicating a Preference to Return to the Community[10]	27.2	21.9
Per capita per diem HCBS expenditures for older adults and people with physical disabilities	$32	$57

Political Factors That Shaped Michigan's LTC System

Michigan's long-term support system has been shaped by many political factors. This section describes how each of these factors, detailed below, impact Michigan's long-term care services system and its reform initiatives.

- A legacy of home and community-based waiver services for people with developmental disabilities, with only one remaining ICF/MR.
- A history of home and community-based waivers for the elderly and persons with disabilities and State Plan in-home personal care service called Home Help.
- A strong commitment to person-centered planning and self-determination.
- Established managed care health plans in Medicaid acute/primary care and for persons with mental illness and/or developmental disabilities.
- Settlement of the Eager lawsuit challenging the lack of access to HCBS services.
- The emergence of a strong collaboration between aging and disability advocates.
- The establishment of a Medicaid Long-Term Care Task Force, a process with a resulting report that lays out nine basic strategies designed to rebalance the system according to individual choice.
- The establishment of the Office of Long-Term Care Supports and Services and the Single Point of Entry demonstration projects, both of which were eliminated during FY 2009 as a result of the severe and ongoing fiscal crisis.

[9] AARP, op. cit, page 171.
[10] CMS, MDS Active Resident Information Report Fourth Quarter 2007.

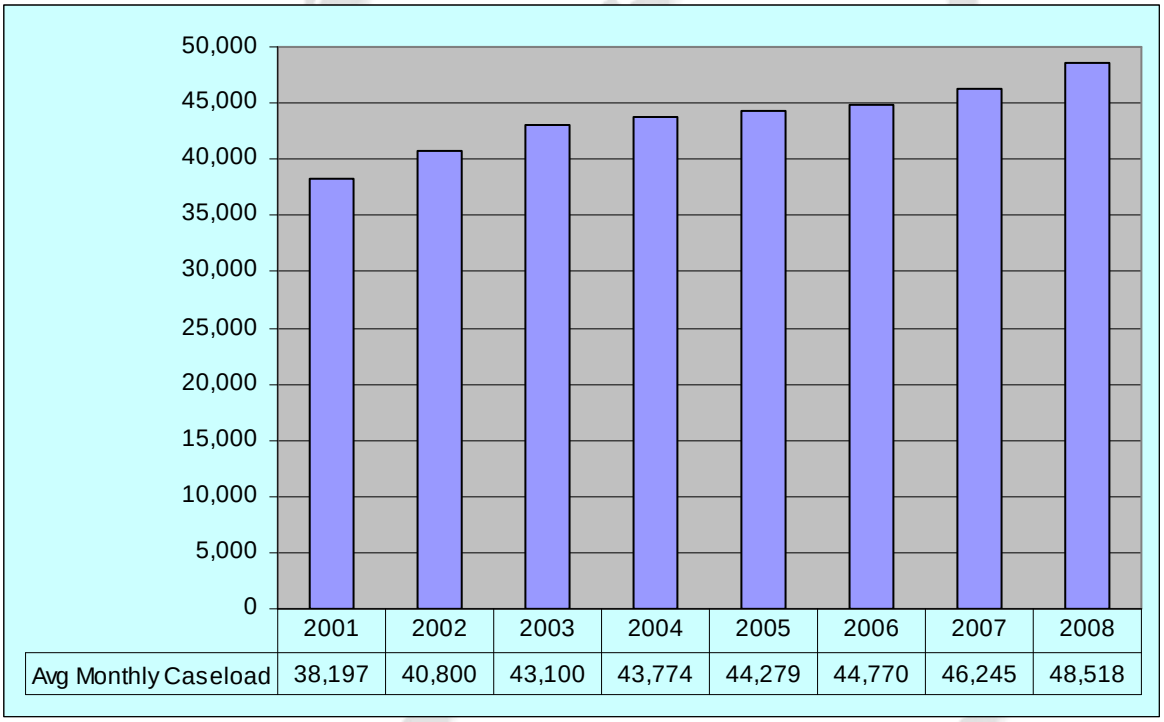
A Legacy of HCBS for People with Developmental Disabilities

Since the late 1970s, Michigan has a long and successful legacy of rebalancing its long-term care system for persons with developmental disabilities. It has been at the forefront in closing its large ICF/MR system, with only one large facility remaining, and had one of the first home and community-based waivers for persons with developmental disabilities in the nation. Strong leadership in the Governor's administration from the late-1970s to the 1990s facilitated this change. In 2010, Michigan intends to become the largest state in history to close all of its ICF/MR facilities.

A History of HCBS for the Elderly and Persons with Disabilities

Michigan established a Medicaid State Plan personal care service, known as Home Help, in 1982. Home Help assists individuals to remain in their own homes by providing hands-on support for Activities of Daily Living as well as Instrumental Activities of Daily Living. It is Michigan's largest HCBS program serving over 48,000 people in Fiscal Year 2008.[11]

Table 1-4 Home Help Caseload
FY2001 - FY2008

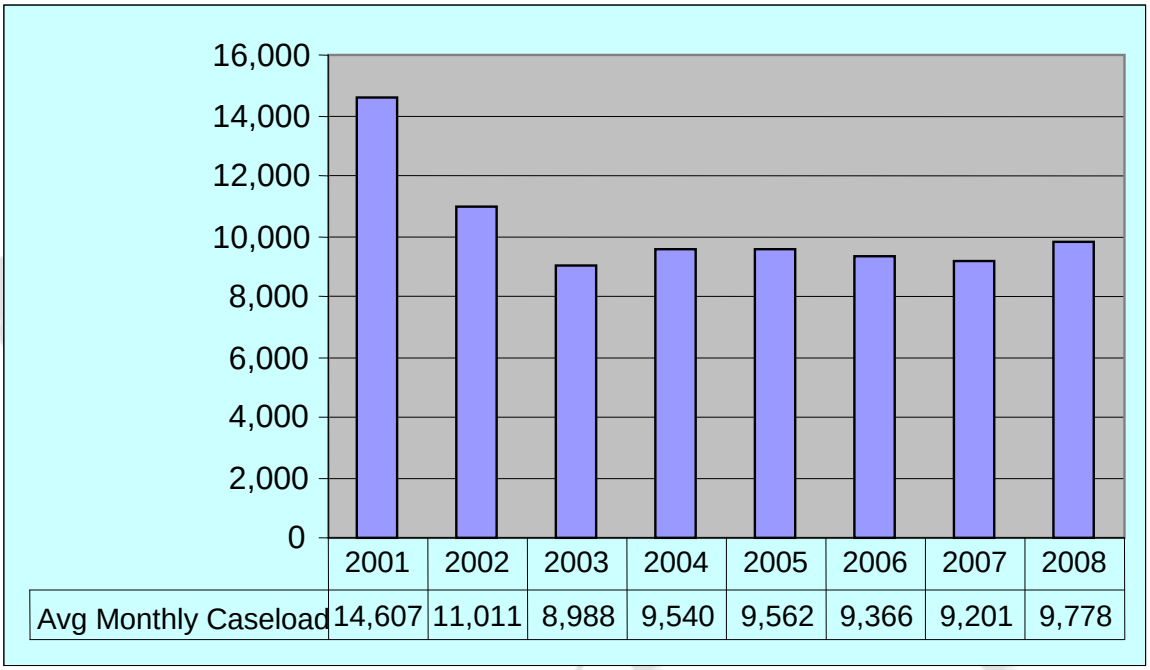


	2001	2002	2003	2004	2005	2006	2007	2008
Avg Monthly Caseload	38,197	40,800	43,100	43,774	44,279	44,770	46,245	48,518

The MI Choice waiver program was first developed in 1992 and expanded statewide in 1998 to provide home and community-based services to physically disabled adults and elderly people who need a nursing facility level of care. The program served 9,699 persons in FY 2008.[12]

[11] Department of Human Services, Program Descriptions FY 2010 http://michigan.gov/documents/dhs/DHS-PgmDescFY2010_267247_7.pdf
[12] DCH Data Warehouse.

Table 1-5 MI Choice Waiver Program Enrollments
FY2001 - FY2008



	2001	2002	2003	2004	2005	2006	2007	2008
Avg Monthly Caseload	14,607	11,011	8,988	9,540	9,562	9,366	9,201	9,778

Strong Commitment to Person-Centered Planning and Self-Determination

Michigan has a long-standing commitment to person-centered planning (PCP), codifying a mandate for the process in the Michigan Mental Health Code. A requirement for PCP has been added to the MI Choice waiver and several nursing homes are working to integrate PCP in that setting. Recently, PCP has been introduced to the aging service delivery system and will serve as the basis of a partnership between the Veterans Administration and the Office of Services to the Aging to implement a person-centered home and community-based service program for veterans in Michigan.

Self-direction, referred to as self-determination in Michigan, has been an option since 2000 in the mental health system for persons with developmental disabilities. A self-determination option was added to the MI Choice waiver in 2007. Home Help, the State Plan personal care service, is Michigan's original self-directed service option.

Established Managed Care Health Plans

Michigan is one of the first states to implement a combined 1915(b)(c) waiver for persons with developmental disabilities and mental illness. This is further discussed in Sections 4 and 5.

Michigan also implemented managed health care for Medicaid in the late-1990s that has a high approval rating. A managed care system for Children with Special Health Care Needs was discontinued in 2003. At present, the long-term care supports and services system has not initiated a managed care demonstration, however, it continues to explore best practices and develop plans to do so.

Settlement of Eager lawsuit

In 2002, after funding reductions in the MI Choice waiver program resulted in the virtual closure of the program to new applicants, five advocacy organizations representing people with disabilities and seven individuals filed *Eager, et al. v Engler, et al.* The suit accused the state of violating both Medicaid law and the Americans with Disabilities Act.

A Stipulation of Settlement was signed on February 2, 2004 that provided immediate relief for the seven individuals who filed the lawsuit, and created the stepping stones for systemic change in Michigan's long-term care system. The settlement required that:

- the MI Choice waiver program be reopened to new applicants.
- all surviving named plaintiffs be admitted to the MI Choice program.
- the state implement a screening tool for applicants to nursing home care and the waiver program.
- the state provide education regarding long-term care options, including:
  - to individuals and families, at the time of application for Medicaid funded LTC,
  - to individuals and families upon admission to a nursing facility or the MI Choice waiver program, and
  - annual training on HCBS waivers for hospital discharge planners.
- the state create a waiting list for applicants to the MI Choice program.
- the state attempt to obtain funding for one-time transition services for nursing home residents seeking to return to the community.
- the state establish a Medicaid Long-Term Care Task Force.

The Emergence of a Strong Collaboration between Aging and Disability Advocates

Prior to the filing of Eager v. Engler, disability rights and senior advocates pursued separate advocacy agendas and engaged in only occasional interactions. The filing of the lawsuit created a concrete reason for these two advocate communities to unite as the Michigan Olmstead Coalition to fight for the expansion of community-based long-term care services. Members of the Coalition share a rich body of long-term care and community-based history and knowledge, and a willingness to learn from each other. As a result, they built relationships of respect and shared commitment and began formulating advocacy strategies and goals in a carefully coordinated manner. This collaboration of advocates increased the influence of professional and consumer advocates in the ensuing years.

The Establishment of a Medicaid Long-Term Care Task Force

Established in 2004, the task force was comprised of seven advocates, three state human service agency directors, four legislators and seven providers who were charged with the duty to examine the long-term care (LTC) system and make recommendations to improve quality, expand the reach of home- and community-based services, and reduce barriers to an efficient and effective continuum of LTC services in Michigan. The task force met for a year and published a 46 page report containing nine recommendations[13]. This report was immediately made a living document.

[13] http://michigan.gov/documents/Final_LTC_Task_Force_Report_159990_7.pdf

The Establishment of Office of Long-Term Care Supports and Services and Single Points of Entry Demonstration Sites

In June of 2005, upon receipt of the Task Force report, Governor Granholm issued Executive Order 2005-14.[14] It specifically addressed the following three recommendations:

- create an Office of Long-Term Care Supports and Services (OLTCSS) within the Department of Community Health to ensure the recommendations were implemented,
- create the Michigan Long-Term Care Supports and Services Advisory Commission to ensure stakeholder input to the reform efforts, and
- establish a minimum of three pilot sites for regional single point of entry agencies.

The balance of this State Profile report contains the progress made since the Medicaid Long-Term Care Task Force issued their report, and will highlight areas which remain to be reformed. Much of the information was gathered by a professional researcher through interviews of state employees administering various programs, and by the participation of twenty dedicated long-term care professionals, advocates and consumers who continue to serve on the State Profile Grant stakeholder advisory group. The group met several times over a period of three and a half months to review the information, add their personal knowledge and experience, and make recommendations to improve the lives of Michigan citizens who use long-term care supports

[14] http://www.michigan.gov/gov/0,1607,7-168-21975_21979-119823--,00.html

SECTION 2: SYSTEM ADMINISTRATION AND MANAGEMENT

Like many states, Michigan has long had a fragmented administrative structure for long-term care supports. Historically, programs were located in various departments, bureaus and divisions based on the source of funding, the characteristics of program participants, or other factors. Many state agencies have county offices serving the same population. In many cases, the state and county agencies for a particular population developed independently of other agencies.

In 2004, the Governor established the Michigan Medicaid Long-Term Care Task Force (LTCTF) to examine the long-term care system and make recommendations to improve quality, expand the reach of HCBS, and reduce barriers to an efficient continuum of LTC services. Progress has been made toward implementing Task Force recommendations; however, significant ongoing effort will be necessary if Michigan is to achieve the vision of the task force

This section provides basic information on Michigan's management of long-term care supports. It briefly describes the various landmarks in Michigan's long-term care landscape, progress in long-term care reform, and challenges to creating an efficient and accessible system. It starts with a basic overview of the agencies involved, followed by recent organizational changes and new initiatives. The roles of the state legislature and consumers are then further described.

Organizational Structure

The majority of long-term care supports and services are administered by various divisions of the Department of Community Health (DCH), including the Medical Services Administration (MSA), the Office of Services to the Aging (OSA), and the Mental Health and Substance Abuse Administration (MHSAA). The Department of Human Services (DHS) determines financial eligibility for many assistance programs and administers programs to provide supports and services to low-income long-term care consumers. The Department of Corrections (DOC) is responsible for inmates who require long-term care services. Programs related to housing and the long-term care workforce are housed in the Department of Energy, Labor and Economic Growth (DELEG).

The organization of long-term supports within Michigan has historically been structured around major population groups with a designated lead state agency for each group. Most of the state agencies have a corresponding network of local agencies with overlapping duties, including:

- providing information and assistance;
- assessing functional or clinical eligibility for services;
- enrolling participants in HCBS programs; and
- providing case management or supports coordination to help people obtain necessary services.

In discussing long-term care system administration and management, this section will focus primarily on the programs and advocacy efforts broadly available to all long-term care consumers regardless of their specific disability. Other sections of the report explain in detail the services available to special populations.

DEPARTMENT OF COMMUNITY HEALTH

Office of Long-Term Care Supports and Services (OLTCSS)

Executive Order 2005-14 created the Office of Long-Term Care Supports and Services within DCH and charged it with administering activities to implement the recommendations of the Medicaid Long-Term Care Task Force; coordinating state planning for long-term care supports and services; reviewing and approving long-term care supports and services policy formulated by state departments and agencies for adoption or implementation; conducting efficiency, effectiveness, and quality assurance reviews of publicly-funded long-term care programs; identifying and making recommendations to the Director of the Department regarding opportunities to increase consumer supports and services, organizational efficiency, and cost-effectiveness within Michigan's long-term care system; and overseeing the implementation of the single point of entry demonstration programs. Due to state budget-cutting activities, the OLTCSS was eliminated by Executive Order 2009-3 effective 10/1/2009 and its duties reassigned.

Since its creation, the OLTCSS has taken primary responsibility for long-term care reform activities supported by CMS Real Choice Systems Change grants and the New Freedom Initiatives. The OLTCSS is working closely with the Medical Services Administration on efforts such as developing a case mix reimbursement methodology and a managed long-term care demonstration project, and overseeing the single point of entry demonstration projects. It has begun to address pressing issues including quality of services and the collection of essential data. As noted below, OLTCSS has also engaged in outreach and education efforts and invited significant consumer input.

Medical Services Administration (MSA)

The MSA is the single state agency for the Medicaid program. It manages the state's Medicaid budget, ensures payment to all Medicaid certified providers, and develops policies and procedures for all Medicaid funded programs. MSA has taken the lead in expanding funding for the MI Choice program and nursing facility transitions, and in seeking to implement policies which promote modest rebalancing from institutional to community-based care. MSA has also maximized reimbursement available to nursing facilities through the use of the Quality Assurance Assessment Program (QAAP). In developing its initiatives and policies, MSA has invited and been responsive to consistent input from long-term care consumers and their advocates including monthly meetings between high-level MSA staff and members of the state's Olmstead Coalition, a coalition of senior and disability advocates.

Office of Services to the Aging (OSA)

The OSA is Michigan's designated state unit on aging operating as an autonomous agency within the DCH. Under the authority of the Older Americans Act (OAA) and Older Michiganians Act (OMA), OSA funds a variety of in-home and community services through area agencies on aging and local service providers. Services are targeted to frail individuals age 60 and older and their caregivers.

OSA's annual budget and activities are reviewed by the Commission on Services to the Aging whose fifteen members are appointed by the Governor and responsible for advising the Governor and the legislature on coordination and administration of state programs, state and federal developments in aging, and priorities for Michigan's aging population.

State Long-term Care Ombudsman Program (SLTCOP)

OSA houses the SLTCOP and administers contracts to fund local ombudsman programs across the state. Ombudsmen advocate for residents' rights and quality of care and life in licensed nursing facilities, adult foster care homes, and homes for the aged. They help to identify and support nursing facility residents who wish to transition to the community. The SLTCOP is funded through Title VII of the Older Americans Act and, in FY 2009, with Civil Monetary Penalty funds. Program capacity is a major challenge and staffing constraints impact the availability of ombudsmen in some settings. Michigan has one ombudsman for every 4,600 licensed beds, exceeding the recommended national standard of one ombudsman per 2,000 licensed beds. The State Ombudsman is a strong advocate both for quality of care and life for individuals in facilities and for rebalancing the state's long-term care system.

Area Agencies on Aging (AAAs)

OSA also oversees the state's sixteen area agencies on aging. Through a vast provider network, AAAs make available care management; case coordination and support; and other services, such as home delivered meals and personal care, that are often components of individuals' long-term care supports and services plans. Fourteen AAAs also serve as MI Choice waiver agents under contract with the DCH, making them a critical component of the HCBS delivery system.

County Commissions/Councils on Aging (CoAs)

CoAs serve as a critical component of the service delivery system upon which AAAs depend to deliver home and community-based services. These not-for-profit agencies are generally created through a government authority, such as a county commission. There are 53 Commissions and/or Councils on Aging in Michigan.

Bureau of Health Systems (BHS)

The BHS licenses and certifies private nursing facilities, county medical care facilities, and hospital long-term care units. It is responsible for conducting the federally mandated annual surveys and investigations of complaints and facility-reported incidents. Investigations of even serious complaints are sometimes delayed.[15] When all budgeted positions are filled there are 2.1 surveyors per 1,000 licensed beds.[16] While both complaints and facility-reported incidents classified as immediate jeopardy are, on average, investigated within three days, the average length of time for all complaint investigations is 104.74 days.[17]

BHS is involved in some voluntary and all involuntary nursing facility closures, responding pursuant to a carefully developed, interagency nursing facility closure protocol to assure the safe and orderly transfer of residents.

Certificate of Need Policy and Program Sections

DCH also houses the Certificate of Need (CON) program, a state regulatory program intended to balance the cost, quality, and access of Michigan's health care system. CON is governed by Part 222 of Public Act 368 of 1978, as amended. An 11-member Commission, appointed by the Governor and confirmed by the Senate, has the responsibility to develop, approve, disapprove, or revise CON Review Standards used to issue decisions on CON applications. In 2008, the Commission adopted health and safety standards for nursing facilities to prohibit the issuance of

[15] DCH Bureau of Health Systems Report to the Legislature, October, 2008, http://www.michigan.gov/documents/DCH/714_10_30_08_265298_7.pdf
[16] DCH Bureau of Health Systems, Mike Dankert, January 2009.
[17] DCH Bureau of Health Systems Report to the Legislature, October, 2008, http://www.michigan.gov/documents/DCH/714_10_30_08_265298_7.pdf

certificates of need to certain providers who demonstrate a significant inability to meet federal and state standards.

Mental Health and Substance Abuse Administration (MHSAA)

The MHSAA carries out responsibilities specified in the Michigan Mental Health Code and the Michigan Public Health Code and administers Medicaid waivers for people with developmental disabilities and serious emotional disturbance. MHSAA is also responsible for persons with mental illness, and substance disorders. Locally, services are delivered through 46 county-based community mental health services programs (CMHSPs). Each region is required to have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service for adults are developed using a person-centered planning process. While not all consumers who utilize these services require long-term care, there is considerable overlap between the long-term care population and those who utilize mental health, developmental disability, and substance abuse services.

DEPARTMENT OF HUMAN SERVICES (DHS)

The DHS performs many critical functions for Michigan's long-term care system. Caseworkers determine financial eligibility for Medicaid funded long-term care services and other public benefits, such as food assistance, on which many long-term care consumers rely. DHS serves as an agent of the MSA in administering a personal care program known as Home Help, an optional service provided under Michigan's Medicaid state plan. The Bureau of Child and Adult Licensing is responsible for licensing and inspecting homes for the aged and adult foster care homes. Adult and Child Protective Services and Adult and Child Foster Care Placement are also the responsibility of DHS. These critical functions are described in further detail in Section 3.

The county-based DHS also administers programs for families and children.

MICHIGAN STATE HOUSING DEVELOPMENT AUTHORITY (MSHDA)

Adequate housing is a crucial infrastructure support to many Michigan residents who need or utilize long-term care supports and services. Access to affordable, accessible housing is consistently identified as a barrier to individuals in nursing facilities who would prefer to live in the community.[18] MSHDA is both a public housing agency and a state governmental entity. It manages public housing units across Michigan in both urban and rural communities. MSHDA faces significant challenges in providing affordable housing to seniors and people with disabilities who also have long-term care needs, including lack of housing programs, vouchers, and subsidized housing units for individuals less than 62 years of age.

DEPARTMENT OF ENERGY, LABOR AND ECONOMIC GROWTH (DELEG)

The DELEG has substantial impact on Michigan's array of long-term care services, including employment services and supports to people living with disabilities. DELEG also houses the Michigan Rehabilitation Services (MRS), Michigan Commission for the Blind, and Michigan Commission on Disability Concerns. MRS is the conduit for state and federal funding to fifteen Centers for Independent Living (CIL) for core funding of operations and specific services, such as personal assistance services and employment training services to people with disabilities. Through its Bureau of Workforce Transformation, DELEG's local agencies and agents provide resources to long-term care providers, employers looking for employees, and people looking for

[18] Extrapolated from the Nursing Facility Transition database 2000 to 2008

work and careers. The DELEG regional skills alliances (RSA) provide a framework to organize the workforce development needs of a particular Michigan business or industry sector and are focused on developing a skilled workforce and to connect Michigan citizens to good jobs with opportunities for career advancement. Several RSAs have focused on the long-term care sector with significant results in creating career paths for direct care workers and supporting the creation of more educational programs.

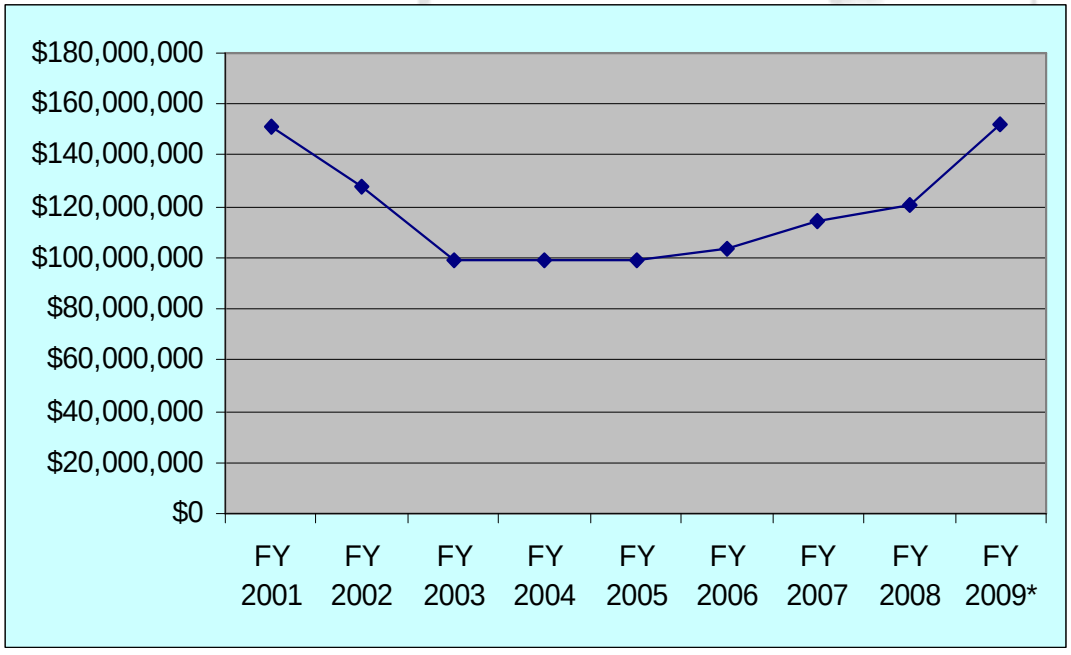
Recent Organizational Changes

In creating the OLTCSS, the Governor recognized the need for improved coordination and planning regarding the disparate long-term care supports and services administered by various state departments and agencies. In abolishing the OLTCSS, the Governor recognized the continued need for such efforts, but regrettably acknowledged that they would have t be accomplished by integrating them back into the mainstream activities of the DCH. And, although the OLTCSS, with the help of this state profile grant, made progress in identifying and understanding the ways in which the various governmental entities are providing services to a wide variety of long-term care consumers, the programs continue to be housed in different departments, with different eligibility requirements, different access points for consumers, and varying degrees of consumer involvement in the development of the programs. Long-term care services will remain a challenge to administer and coordinate.

Legislative Involvement

The state legislature has played a major role in Michigan's attempts to rebalance the LTCSS system. After freezing MI Choice program funding at $100 million for several years, the legislature has increased funding each fiscal year since 2006.

Table 2-1 MI Choice Waiver Program Funding[19]
FY2001 - FY2009



[19] DCH Data Warehouse

In addition, in 2006 the legislature passed Public Act 634, a bill that created four single point of entry demonstration sites. Due to severe and ongoing budget issues, the demonstrations were eliminated effective June 1. Although there is considerable support within the administration and among advocacy groups for a single, rolled-up line item that could promote flexibility in service delivery, the legislature has continued to allocate funding in separate lines for nursing facility care and HCBS services

Michigan's Rebalancing and Systems Change Initiatives

Michigan has engaged in a number of systems change initiatives to rebalance funding for long-term care services and to create a system that is person-centered. The Medicaid LTCTF laid the groundwork for reform as detailed in the Background section. The creation of the Office of Long-Term Care Supports and Services, the acquisition and implementation of the federal grants, the creation of the single point of entry demonstration projects, the emphasis on person-centered planning, the option of consumer self-determination in the Home Help and MI Choice programs, and increased funding for both MI Choice and the nursing facility transition initiatives demonstrate a positive shift toward rebalancing.

As reflected in the following tables, both expenditures and days of care reflect a gradual rebalancing of funding from institutional to community-based services[20].

Table 2-2 Medicaid LTC Expenditures 2005-2009

Program	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009 (Appropriated)
Nursing Facilities	$1,401,208,554	$1,443,059,862	$1,537,427,947	$1,520,584,123	$1,515,591,000
MI Choice Waiver	$98,949,647	$103,341,137	$114,011,761	$120,670,468	$152,424,900
Home Help	$186,060,539	$188,232,394	$229,146,725	$243,074,432	$258,789,300
Personal Care Supplement	$15,220,586	$15,011,981	$16,149,754	$15,029,917	$19,247,500
PACE	$6,085,021	$6,112,605	$7,520,463	$9,457,458	$15,250,000

Table 2-3 Medicaid LTC Days 2005-2009

Program	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009 (Projected)
Nursing Facilities	10,519,837	10,373,993	10,145,719	9,487,549	8,945,247
MI Choice Waiver	2,585,795	2,545,313	2,543,542	2,545,438	3,085,114
Home Help	16,161,835	16,341,141	16,879,577	17,757,466	10,100,923
Personal Care Supplement	2,654,889	2,476,486	2,664,181	2,486,237	3,043,169
PACE	70,475	78,749	92,467	108,916	164,498

In FY 2008, for the first time, nursing facility expenditures declined as the result of rebalancing efforts. While the state spent $1,537,427,947 in FY 2007 on nursing facility care, it reduced that spending by nearly $17 million in FY 2008 ($1,520,584,123). At the same time, MI Choice spending increased from $114,011,761 to $120,670,468 and Home Help spending increased from

[20] Ibid.

$214,819,841 to $226,669,675. The FY 2009 appropriation for the MI Choice program increased to $152.4 million which brings the spending for HCBS to its highest level ever in Michigan.

While nursing facility occupancy rates in 2007 were approximately 87%, leaving 13% of beds unoccupied across the state,[21] the waiting list for MI Choice services sometimes exceeded 4,000 people[22]. Some residents in nursing facilities who express a desire to transition to the community experience barriers, including the capacity and resource constraints in some communities, difficulty finding affordable and accessible housing, resistance by guardians or family members, and other factors. Because of differing eligibility criteria, some consumers who qualify financially for Medicaid funded nursing facility care do not qualify for HCBS. Some of these individuals are therefore unable to transition out of nursing facilities or are forced to enter nursing homes to receive, or continue to receive, the services and supports they need.

DCH is currently planning several other aspects of long-term care reform including:

- The availability of MI Choice waiver services in licensed adult foster care homes and homes for the aged and in low-cost housing options developed in collaboration with the MSHDA,
- The establishment of case mix reimbursement methodologies in both the MI Choice waiver and nursing facilities,
- The development of a prepaid, integrated and capitated acute and long-term care waiver, and
- Improving quality of life outcomes for long-term care consumers in all settings.

Long-term Care Quality Management

The Medicaid LTCTF defined long-term care quality as:

> "A quality long-term care experience is an individual evaluation. Quality is defined and measured by the person receiving supports, and not through surrogates (payers, regulators, caregivers, families, professionals and/or advocates). The elements of quality are meaningful relationships, continuity of community involvement in the person's life, personal well-being, performance measures, customer satisfaction measures, the dignity of risk taking, and the freedom to choose or refuse available options."[23]

The LTCTF found gaps in Michigan's long-term care quality oversight. These efforts are scattered among several state agencies, resulting in a variety of standards, goals and approaches, and no consistent policy or budgetary approach to promoting and ensuring quality across the system. The lack of a central point for quality management of the long-term care system is a critical issue for consumers and policymakers alike.[24] Several strategies[25] were recommended by the LTCTF to address these gaps and some of these have already been implemented.

Prior to the LTCTF report, Michigan had taken steps to enhance quality in long-term care supports and services. Under Real Choice System Change grant activities, DCH established and has continued the MI Choice Quality Management Collaborative as described below.

[21] AARP, op. cit., page 172.
[22] http://michigan.gov/documents/DCH/16892_08_01_08_250190_7.pdf
[23] Medicaid Long-Term Care Task Force Report 2005, p. 20.
[24] Ibid
[25] Ibid

MI Choice Person Focused Quality Management Collaboration

Michigan enhanced its quality strategy (quality management plan) with meaningful contributions from consumers who participated in monthly meetings with the DCH and provider staff from March, 2004 through September, 2005. A leadership group comprised of seven consumers and seven providers organized formally into the MI Choice Person-Focused Quality Management Collaboration to work on developing a person focused plan. The Collaboration brings providers and consumers together to review and measure outcomes, identify issue areas, recommend strategies for improvement, and establish an open forum for the exchange of ideas and best practices.

Achievements of the Collaboration include:

- Adoption of a quality outcome review methodology that examines performance outcomes (data) drawn from the Michigan Minimum Data Set for Home Care (MDS-HC) Assessment System called Quality Indicators.
- Participation in the review and updating of contract requirement documents that describe minimum standards for the operation of the waiver program. Members provided recommendations for person focused edits. The quality strategy includes updating service standards and contract requirements as needed to assure the health and welfare of waiver participants.
- Provision of advisory oversight to the Participant Experience Survey (PES) Project. With this project, managed by the Michigan Disability Rights Coalition (MDRC), peers interviewed MI Choice participants in their homes to test the CMS PES. The PES survey focused on how participants perceive their services are delivered along the four CMS Quality Framework domains of: access to care, choice and control, respect and dignity, and community integration.

Consumer Involvement

Under the Granholm administration, the state has been especially energetic in reaching out to consumers and their advocates and inviting their participation in and counsel about long-term care reform. In addition to strong consumer membership on the LTCTF and the Long Term Care Supports and Services Advisory Commission, the DCH staffs the Consumer Task Force which has met for many years to assist in the development and monitoring of the Department's progress on its systems change grants and initiatives. The DCH has also created shorter term advisory groups with strong primary and secondary consumer membership and a more specific focus including the Michigan Person Focused Quality Management Collaboration for the MI Choice waiver program (described above), the Money Follows the Person Stakeholder Council, the Nursing Facility Transition Pathway Workgroup, the Systems Transformation Grant forum, the State Profile Tool Advisory Council, and a workgroup to assist the DCH in seeking its most recent MI Choice waiver renewal. In addition, the Department held a long-term care conference in 2006 which drew more than 500 participants including consumers, advocates, and professionals from across the state. The OLTCSS holds frequent forums for consumers and providers to share updates and provide information on a variety of topics. Moreover, the staffs of both the MSA and the OLTCSS meet monthly with representatives of the Olmstead Coalition to discuss progress on long-term care reform and issues of concern to consumers.

In the past seven years, Michigan's aging and disability advocacy communities have developed an exceptionally close collaboration and carefully coordinated advocacy efforts to expand home and community-based care and promote quality across the spectrum of long-term care supports and services. Advocates from the two communities have come to understand and respect each other's

different histories, vocabularies, and values and jointly establish priorities and strategies to achieve them. As one advocate noted recently, when state officials talk about "the advocates" they no longer distinguish between aging advocates and advocates for people with disabilities.

The primary vehicle for this collaboration has been the Olmstead Coalition which brings together advocates from both communities as well as representatives of direct care workers. The Coalition has monthly meetings for its members, and representatives of the group meet regularly with DCH officials and legislators. Groups who participate in the Olmstead Coalition and are active in advocating for long-term care reform include: the Michigan Disability Rights Coalition; the Area Agencies on Aging Association; the State Long-Term Care Ombudsman Program; Service Employees International Union, Developmental Disability Council; ARC Michigan; the Michigan Campaign for Quality Care; Michigan Protection and Advocacy Service, Inc.; the Disability Network/Michigan; UCP Michigan; AARP; Paraprofessional HealthCare Institute, ADAPT, the MS Society Michigan Chapter; and the Michigan Quality Care Community Council. Staff from advocacy organizations and some providers from the MI Choice waiver agents, Area Agencies on Aging, Long-Term Care Connections (single point of entry demonstration project agencies), and the state's 15 Centers for Independent Living participate in Olmstead and have joined with other advocates to participate in various advocacy efforts.

Advocates from both the aging and disability communities were members of the Governor's Medicaid Long-Term Care Task Force and its workgroups and continue to serve on the Long-Term Care Supports and Services Advisory Commission and its committees as well as other committees such as the Department's new case mix workgroup and Nursing Facility Transition Stakeholder Council.

SECTION 3: OLDER ADULTS AND PERSONS WITH DISABILITIES

Services for older adults and persons with disabilities are administered across three State of Michigan entities: the Department of Community Health (DCH) Medical Services Administration (MSA), the Office of Services to the Aging (OSA), and the Department of Human Services (DHS). Medicaid is the primary payer for long-term care services delivered in Michigan.

The DCH MSA is Michigan's designated single state Medicaid agency and funds the provision of HCBS and nursing facility services to physically disabled adults age 18+ and elderly individuals age 65 and older. The OSA is Michigan's designated state unit on aging, housed within the DCH. OSA operates under the authority of the Older Americans Act (OAA) and the Older Michiganians Act (OMA) in funding in-home and community services through area agencies on aging and local service providers. Services are targeted to individuals age 60+. The DHS serves as an agent of the MSA in determining financial eligibility for many programs and administering a personal care program known as Home Help, an optional service provided under the approved Medicaid State Plan designed to support individuals age 18+ who are unable to care for themselves adequately at home.

Michigan's array of programs for older adults and persons with disabilities operate largely independent of each other and opportunities exist for streamlining. The annual long-term care budget establishes separate lines for institutional and community-based services which creates barriers to fully implementing money follows the person initiatives. Until June 1, 2009, the four single point of entry demonstration projects were responsible for conducting level of care determinations (LOCD) for individuals seeking Medicaid funded long-term care services in their catchment area, but had no authority or role other than on a referral basis over access to either aging services or to the Home Help program. Upon their elimination, responsibility for conducting LOCDs reverts back to providers (nursing facilities and MI Choice waiver agents) who do not have a good track record for engaging consumers in discussion about other available service options. Finally, a key missing component to the delivery of HCBS is the lack of affordable, community residential alternatives to nursing facilities and the availability of Medicaid funding for such purposes.

Programs and Services – Medical Services Administration

HCBS Programs

Community-based long-term care services provided under Michigan's Medicaid program include the MI Choice waiver program, Program of All Inclusive Care for the Elderly (PACE), Home Help, and personal care services provided in licensed living facilities such as adult foster care and homes for the aged. Individuals participating in Medicaid funded HCBS programs must meet functional and financial eligibility criteria which differ from one program to the next.

The MI Choice program, a 1915(c) waiver, provides supports and services to the elderly and adults with disabilities. MI Choice participants receive their supports and services in the community rather than in a nursing facility. Persons enrolled in the program are entitled to receive all Medicaid state plan services plus applicable MI Choice program services.

Table 3-1 MI Choice Waiver Program Services[26]

Adult Day Health	Personal Emergency Response System
Chore Services	Personal Care
Community Living Supports	Private Duty Nursing
Counseling	Respite Care
Environmental Accessibility Adaptations	Specialized Medical Equipment and Supplies
Home Delivered Meals	Training
Homemaking	Fiscal Intermediary Services*
Non-Medical Transportation	Goods and Services*
Nursing Facility Transition Services	Residential Services (pending CMS approval)

*Services available only to participants choosing the self-determination option

The MI Choice program is targeted to persons age 18 and over with disabilities and elderly age 65+ who are in need of supportive services and choose to receive those services in their home or other community setting. Functional eligibility is determined through the Michigan Medicaid Nursing Facility Level of Care Determination which is conducted by the MI Choice waiver agencies for individuals accessing that program. Individuals who meet financially eligibility have maximum countable income of 300% of the federal SSI benefit level and assets of $2,000 or less. MI Choice agents assess and plan care with the participation of the individual. Options exist for self-direction of some services.

The Program of All Inclusive Care for the Elderly (PACE) features a comprehensive service delivery system and integrated Medicare and Medicaid financing for the provision of primary, acute and long-term care. PACE is targeted to Medicaid eligible individuals aged 55+ who need long-term care supports and meet the nursing facility LOCD. It is not a service option for disabled adults under the age of 55, creating a major service void for younger persons with disabilities who are dually eligible.

Michigan Medicaid provides a specialized program of integrated services not otherwise available outside of an institutional rehabilitation setting for persons aged 18+ with a brain injury and a documented need for continued specialized rehabilitation services. Otherwise, Medicaid covered long-term care services for traumatic brain injury (TBI) individuals are limited. A HCBS waiver for the TBI population is being developed by MSA.

Non-HCBS Programs

Institutional long-term care services are provided in nursing homes, county medical care facilities, hospital long-term care units, and hospital swing beds. Individuals receiving Medicaid funded nursing facility services must meet functional and financial eligibility criteria. Functional eligibility is determined using the same tool used to determine eligibility for HCBS programs. The LOCD is conducted by providers (nursing facility admissions personnel) except in SPE demonstration areas, where it is conducted by options counselors.

Medicaid is the primary payer of institutional long-term care services provided in Michigan. Nursing facility providers are taxed based on their non-Medicare days. Provider fees generated through the QAAP are used to draw federal Medicaid funding to support the provision of institutional long-term care services.

[26] http://www.michigan.gov/documents/DCH/1915-c_HCBS_Waiver-6-2007_205659_7.pdf

Programs and Services – Office of Services to the Aging

HCBS Programs

Community-based long-term care services funded by OSA and delivered through the aging network include adult day care, care management, caregiver services, case coordination and support, chore services, friendly reassurance, home delivered meals, homemaker, home health aide, home injury control, personal care, personal emergency response, and respite. They are funded through a combination of Older Americans Act (40%), state general fund dollars (31%) and local resources (29%). There is currently a voter approved, senior designated property tax millage in effect in 65 of Michigan's 83 counties and an additional 33 townships and cities which generated revenues of more than $70 million in 2007.[27]

Aging network services are targeted to individuals age 60 and older with functional limitations that affect their ability to conduct ADLs and IADLs. Priority is given to low-income minority individuals in economic or social need as required by the Older Americans Act (OAA). The 100% state-funded care management program serves as a safety net for MI Choice participants, including those under age 60, who temporarily lose Medicaid eligibility or are otherwise disenrolled from the waiver program.

Table 3-2 Select OSA-Funded HCBS 2007[28]

Service	*# Served*	*Expenditures*
Adult day care	1,548	$5,217,419
Care management	3,812	$8,788,390
Caregiver services[29]	7,984 caregivers	$14,170,350
Case coordination and support	9,776	$1,326,676
Chore	3,376	$797,815
Friendly reassurance	1,634	$15,713
Home delivered meals	49,717	$34,542,813
Homemaker	7,520	$5,764,555
Home health aide	55	$34,680
Home injury control	1,536	$206,584
Personal care	4,939	$5,727,770
Personal Emergency Response	1,151	$88,467
In-Home and Out of Home Respite	2,401	$4,866,864

To assist those 60 and older who are functionally eligible for nursing facility care but who are not financially eligible for Medicaid, the OSA and area agencies on aging are developing a nursing home diversion initiative. Funded under an Administration on Aging Choices for Independence grant, the program is targeted to older adults with personal financial resources that can be used to purchase services with assistance and support from area agency on aging funded services and case management.

[27] Michigan Department of Treasury, Bureau of Local Government Services, 2/25/2009.
[28] 2007 Michigan Aging Information System, NAPIS Client and Service Report, http://www.michigan.gov/documents/miseniors/2007MichiganProgramReport-Napis_232009_7.pdf
[29] Includes respite, counseling, supplemental, information, and access to services.

Non-HCBS Services

In addition to community long-term care services, adults with disabilities and older Michiganians use a variety of supports that are often vital for community living. Many HCBS participants receive the following supports from the mentioned sources:

- Health insurance and prescription drug assistance from Medicare,
- Congregate dining, nutrition counseling, prevention, senior center activities, and other services from aging network providers,
- Health benefits counseling from the Medicare/Medicaid Assistance Program,
- Grocery payments from the Food Assistance Program,
- Demand-response and specialized transportation services from public transit agencies, and
- Volunteer opportunities through the Senior Companion Program, the Foster Grandparent Program, and the Retired Senior Volunteer Program.

In 2004, Michigan was selected by the CMS to participate in the Background Check Pilot Program and was awarded $1.5 million in additional funding to deliver a comprehensive abuse prevention training program (CMS Grant # 11-P-93042/5-01). Administered by OSA, a main goal of the training project was to expand existing abuse and neglect prevention curricula to incorporate methods of staff empowerment, culture change, and person centered care. The curricula specifically address modifiable aspects of staff work and life that might contribute to abuse or abuse prevention and in which they have some measure of control. Across the state, training was provided to 7,804 long-term care direct access staff working in all long-term care settings as well as the Home Help program. Curricula and training materials are available for continued use and replication.

Programs and Services – Department of Human Services (DHS)

HCBS Programs

Michigan has led the nation with respect to availability and use of personal care services.[30] The Home Help program is an optional state plan service which was established more than three decades ago. The program, which is implemented by DHS but administered and funded by DCH, continues to be instrumental in providing essential services to individuals with disabilities and the elderly and serves as an alternative to some persons who would otherwise have to seek institutional care. Home Help provides assistance with ADLs and IADLs to Medicaid beneficiaries 18 years of age and older who have personal care needs. While participants in the program span the entire adult age range, the highest concentrations of Home Help consumers are between the ages of 41 and 60.

[30] Leblanc, A.J., M.C. Tonner, and C. Harrington, "State Medicaid Programs Offering Personal Care Services," Health Care Finance Revision 22, number 4 (2001), 155-73.

Table 3-3 Age of Home Help Recipients (Average Age Distribution Trend) [31]

AGE	PERCENT
0-20	2.05%
21-30	8.72%
31-40	11.24%
41-50	18.42%
51-60	21.79%

AGE	PERCENT
61-64	6.96%
65-74	14.56%
75-84	11.46%
85-94	4.23%
95+	0.56%

One of the most popular aspects of the program is that services are consumer directed so consumers recruit, hire, train, and fire their own providers. They may choose friends, neighbors, relatives, or employees of a home care agency but spouses, responsible relatives, or their legal dependents are not reimbursed for providing Home Help services. The majority of consumers employ individuals they know. To be qualified a provider must meet minimum requirements related to age, ability, physical health, knowledge, personal qualities, and training.

Consumers who have not identified a provider they wish to employ can contact their local DHS office or the Michigan Quality Community Care Council (MQCCC) for lists of possible providers. MQCCC maintains a registry of providers for which they have conducted a criminal background check, checked the National Sex Offender Registry, and checked references.

The availability of providers varies across the state. As of 2008 most counties paid Home Help providers $7.50 per hour while other counties paid workers from $8.00 to $10.50 per hour. Providers receive no benefits through this program. Moreover, in rural counties, since Home Help providers do not receive reimbursement for travel costs, transportation expenses can be a significant barrier to providers who may sometimes travel long distances to serve consumers.[32]

Home Help provider agencies are typically reimbursed more to account for the overhead of a agency. As of August 1, 2008, the agency rate ranged from $12.75 to $15.50. Some of the provider agencies make benefits available for individuals employed through this program.

The Adult Community Placement (ACP) program provides assistance in locating and selecting licensed community care facilities for people 18 years of age and older who can no longer live independently. Services can be provided both to individuals who are, and are not, eligible for Medicaid but require placement, as determined by a comprehensive assessment.[33] The goal of the program is to provide a range of support and services to enable individuals to live safely in the least restrictive community-based care setting. The program emphasizes the consumer's right to make informed choices, live independently and with dignity, use of the consumer's natural supports, and development of self advocacy skills. Like Home Help, this program strives to be person centered and strength based.

Adult Protective Services (APS) provides protection to any vulnerable adult who is reported to have been abused, neglected, or exploited. The program provides immediate investigation and assessment, and if the victim consents, assistance in finding a safe and stable environment in which to live. While this program may assist individuals in need of long-term care, services are available to any adult who is reported to be at risk from abuse, neglect, or exploitation where there

[31] Department of Human Services, Program Descriptions FY 2010 http://michigan.gov/documents/dhs/DHS-PgmDescFY2010_267247_7.pdf
[32] Providers' testimony to Long-Term Care, Supports and Services Commission, May 19, 2008
[33] Department of Human Services, Adult Services Manual Item 372, http://www.mfia.state.mi.us/olmweb/ex/ asm/372.pdf

is reasonable belief the victim is in need of protective care. Like other DHS programs, APS emphasizes consumer choice and empowerment, person-centered planning, and assisting consumers in the least intrusive and restrictive manner possible. APS faces similar resource issues as other DHS programs. While the national standard for adult protective services is one worker for 25 cases, Michigan's APS staff has an average load of 38 cases and some have more than 50 cases.[34]

Programs and Services – Centers for Independent Living (CIL)

CILs are grassroots, advocacy driven organizations run by and for people with disabilities. They focus on civil rights, an independent living philosophy, and inclusion, and provide individual and systems advocacy, information and referral, peer support, and independent living skills training. CILs are non-residential organizations and are opposed to segregation and the forced institutionalization of people with disabilities of all ages.

Nationally, CILs have been a strong advocacy force to changing or "rebalancing" the long-term care system. Likewise, CILs in Michigan have had a long standing impact and relationship on the LTCSS system. They were critical to the development of the Home Help program, Michigan's long standing self-directed Medicaid state plan personal assistance service. Many CILs have been involved in transitions activities on a limited basis for many years.[35]

Michigan CILs are currently funded by DCH to provide outreach and conduct nursing facility transition services on a fee for service basis. Funding was provided to two CILs on a demonstration basis in 2006 and the effort was expanded to all fifteen CILs in early 2008. Data on the number of transitions completed is provided in Table 3-6 on page 27. It demonstrates a continuing trend of an increase in the number of completed transitions as the process becomes better established, funding increases, and the program is expanded statewide.

Demographic and Utilization Trends

Table 3-4 Michigan Long-Term Care Program Participation 2007[36]

Service	*# Enrolled*
Nursing facility services	41,833
MI Choice waiver	7,899
PACE	222
Home Help	46,245
Adult Community Placement	4,345

Medicaid is the primary payer of nursing home expenditures in Michigan, spending over $1.5 billion in FY 2007.

[34] Cynthia Farrell, Program Manager for Adult Services and HIV/AIDS, DHS, PowerPoint, "Home Help Services: A Joint Program between DHS and DCH," 2008.
[35] Michigan Centers for Independent Living, A Report to the Legislature, http://www.michigan.gov/documents/DELEG dleg/2007_Legislative_Report_1-18-08_224335_7.pdf
[36] DCH Data Warehouse.

MI Choice funding and enrollments have increased steadily in recent fiscal years as a result of nursing facility transition services. An increasing number of transitions are anticipated due to funding from the Deficit Reduction Action Money Follows the Person grant. Demand for the MI Choice program exceeds capacity. There were 3,890 individuals on the wait list at the end of FY 2008.

Michigan has three operating PACE providers serving 338 individuals. One additional program is under development and expected to start enrolling participants in spring of 2009.

Demand for aging network services exceeds capacity. FY 2007 utilization and expenditure data for select aging network services is provided in Table 3-2 on page 22. Through the third quarter of FY 2008 there were 3,163 persons on waiting lists for in-home services and 959 persons on waiting lists for home delivered meals.

In FY 2008, the Home Help program served approximately 48,518 consumers at a total estimated cost of $226.7 million.[37] Both the cost of the program and the average number of clients served per month has increased each year. While the FY 2008 expenditure represents 11.9% of total Medicaid long-term care expenditures, Home Help recipients constitute more than half of all Medicaid funded long-term care consumers.[38] The average monthly cost per Home Help consumer is only $367. This is approximately 8% of the average monthly cost of nursing home care.[39]

Adult Community Placement serves approximately 4,300 individuals annually with a $30 million budget.[40] Funding is used to provide a $192.38 (as of October 1, 2008) monthly personal care supplement to adult foster care homes and homes for the aged that each Medicaid eligible persons residing in their home.

Components Associated with Rebalancing

Streamlined HCBS Administration

As described earlier in this section, HCBS services for older adults and persons with disabilities are administered across three State of Michigan entities: the Department of Community Health (DCH) Medical Services Administration (MSA), the Office of Services to the Aging (OSA), and the Department of Human Services (DHS). Medicaid funded supports are primarily administered through MSA and DHS, while OSA, as the state unit on aging, is responsible for funds provided under the OAA and OMA.

Medicaid long-term care policy is developed, implemented and monitored by MSA. Standards and policies addressing OAA and OMA are the responsibility of OSA. The MI Choice waiver program and the OSA care management (CM) program operate concurrently in 14 of 16 area agencies on aging, where CM serves as a safety net for MI Choice participants, including adults with disabilities age 59 and under, who temporarily lose Medicaid eligibility or are otherwise disenrolled from the waiver program.

There are significant opportunities for streamlining administration of HCBS in Michigan.

[37] Department of Human Services, Program Statistics FY 2007 and FY 2008, http://michigan.gov/documents/dhs/DHS-PUB-0170-2007_219125_7.pdf
[38] Ibid
[39] Ibid
[40] Ibid

Single Access Points

In response to a key recommendation of the Medicaid Long Term Care Task Force, DCH established four single point of entry (SPEs) agencies on a demonstration basis to provide information and assistance and options counseling to Michigan citizens seeking long-term care services. Due to severe and continuing budget shortfalls, the demonstration projects were eliminated effective June 1, 2009 by Governor Granholm in Executive Order 2009-22. The demonstration areas encompassed approximately 53% of the state's elderly and disabled population. The primary services provided by the SPEs, known as Long-term Care Connections (LTCC) included information and assistance (I&A), options counseling (OC), nursing facility LOCD, and management of the MI Choice wait list. In non-demonstration areas, these tasks have continued to be conducted by Area Agencies on Aging, nursing facilities and MI Choice waiver agents. With the elimination of the SPEs, work must be done to integrate these important services into existing delivery systems.

Institutional Supply Controls

Michigan is one of 36 states that control nursing facility bed supply through a Certificate of Need (CON) program. A CON is required when a provider initiates, upgrades, expands, relocates or acquires a covered health service or entity. Michigan's CON bed inventory exceeds need by nearly 3,000 beds. At about 41.3 beds per 1000 elderly age 65+, Michigan has significantly fewer nursing facility beds than the national average of 52.2 beds per 1,000. The number of licensed beds continues to decrease as providers renovate facilities and develop specialty-care units.

Table 3-5 Michigan Bed Supply 2004-2008[41]

Fiscal Year	*# of Beds*
2004	49,343
2005	48,852
2006	48,204
2007	48,319
2008	46,982

Transition from Institutions

Under the CMS Money Follows the Person initiative, MI Choice waiver agents and Centers for Independent Living (CILs) facilitated 1,358 transitions from 2005-2008. Transitions are funded through Medicaid and Civil Monetary Penalty funds. Waiver agents fund transition activities under contract with the DCH MSA, working primarily with individuals that will enroll in the MI Choice program at discharge. CILs contract with DCH to facilitate transitions on a fee-for-service basis for individuals who wish to transition but do not enroll in the waiver.

[41] March 2009, Bed Inventory, CON, DCH

Table 3-6 Nursing Facility Transitions 2006-2008[42]

Fiscal Year	*MI Choice Transitions*	*CIL Transitions*
2006	267	19
2007	406	49
2008	517	88

Continuum of Residential Options

Michigan Medicaid policy establishes patient-pay provisions for Medicaid coverage for nursing facility care that do not exist for home and community-based settings. If an individual is over the income limit, the only Medicaid LTC option becomes a nursing facility.

There is a lack of affordable setting options between the home and the nursing facility. Current Michigan policy does not allow individuals who qualify for HCBS waivers to receive services in licensed assisted living settings (adult foster care or homes for the aged).

Building Infrastructure

The elimination of the SPE demonstration projects poses significant challenges and sets Michigan's system change efforts back several years. Effort will be made in the coming months to ensure the integration of SPE best practices and functions into the day-to-day business practices of existing agencies.

DCH is developing a service definition and provider requirements for submission to CMS that would establish residential services within the MI Choice waiver. Doing so will provide additional community-based options to individuals with nursing facility level of care needs.

Michigan was one of seven states selected to participate in the federal background check pilot program. Nursing homes, county medical care facilities, hospitals with swing bed services, Medicare-certified home health agencies, ICF/MR facilities and psychiatric facilities, adult foster care and homes for the aged, and inpatient programs must comply with Public Acts 26, 27, 28 and 29 of 2006 which prohibit the hiring, independently contracting with, or granting of clinical privileges to individuals who have regular direct access to or provides direct services to patients or residents until a criminal history background check has been conducted. The Michigan Workforce Background Check program consists of two major components: a web-based application that allows employers to search available registries for potentially disqualifying information, and a state and federal fingerprint records check by the Michigan State Police.

A nursing home diversion process for non-Medicaid individuals is being developed by OSA and the AAAs under an OAA Choices for Independence grant. Considerable effort has focused on development of person-centered thinking and organizational culture change. An additional component of this initiative is the development of flexible service options within Older Americans Act programs. These efforts have resulted in enhanced competencies and the broad implementation of person-centered planning and self-determination within AAA service programs. Efforts to further embed the concepts and broader implementation are ongoing under a second grant award from AoA.

[42] Nursing Facility Transition Data Base, March 2009

The affordable assisted living (AAL) initiative has been established by the Michigan State Housing Development Authority to link MI Choice waiver services with affordable housing for low and moderate income Michigan residents. Five housing demonstration projects have been approved and are in various stages of development to make 160 apartments available to individuals age 55+ with incomes at or below 50% of the area median income with a nursing facility level of care. Due to age restrictions, the AAL initiative is not an option for individuals with disabilities who are younger than 55.

Participant Direction

Self determination (SD) has been an option within the MI Choice waiver program since October 1, 2007. Over 900 MI Choice participants have enrolled in SD since that date. Individual budgets are managed jointly by participants and fiscal intermediaries. The participant is considered the employer, and has the authority and responsibility to negotiate wages, establish work schedules and supervise the care provider.

SD is an emerging concept within the Michigan aging network. The recently implemented OAA Choices for Independence strategy provides states the flexibility necessary to target funding at individuals rather than service categories. This enables a response to individualized needs and preferences, and enables a shift towards person-centered thinking and away from person-centered care. This shift will include a move toward consumer-directed approaches to service delivery to give individuals more control over the care they receive.

Quality Management

MI Choice waiver agents are bound by service definitions and provider requirements as detailed in the CMS-approved 1915(c) waiver document. Waiver agents are monitored by DCH on an annual basis to determine their compliance with established standards. Waiver agents, in turn, ensure that providers delivering in-home services adhere to the standards through the conduct of annual assessments. The MI Choice quality assurance plan[43] is based on CMS quality initiatives and has been identified as one of the most comprehensive in the nation.

Aging network services are provided in accordance with standards established and approved by the OSA. Regional definitions for specialized services are established by AAAs through the area planning process. AAAs are responsible for identifying and contracting with local service providing organizations as necessary to implement the approved area plan. They are also responsible for monitoring service providers for compliance with established standards.

Summary

As indicated previously, Michigan's array of programs for older adults and persons with disabilities operate independently of each other. Opportunities exist for streamlining within both administration and service delivery. A concentrated effort is underway to develop a closer collaboration between the MSA, the OLTCSS, and OSA at both the program development and service delivery levels. A continuing challenge is the dramatic underfunding/understaffing of HCBS programs and the unrealistic burdens placed on caseworkers, specialists and consultants, which has a direct and serious impact on the quality of care provided to Michigan's elderly and disabled persons.

[43] http://www.michigan.gov/documents/DCH/1915-c_HCBS_Waiver-6-2007_205659_7.pdf

SECTION 4: SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Developmental disabilities (DD) are a diverse group of serious chronic conditions due to mental and/or physical impairments acquired before age 22 and last throughout a person's lifetime.[44] People with DD have problems with one or more major life activities such as language, mobility, learning, self-help, and independent living.

Michigan has a very long and successful history of rebalancing its long-term care system for people with DD. Not only has it been at the forefront in closing its large ICF/MR facilities but one of the first home and community-based waivers in the nation was Michigan's Habilitation/ Supports waiver. Michigan was one of the first states to require by law person-centered planning; and self-determination has been implemented for people with developmental disabilities for over two decades. The State has since used this success in implementing the same for people with serious mental illness.

While increasingly larger numbers of people with DD are living on their own with supports, remnants of the former system still exist. There are still too many who reside in group homes that developed in response to the rapid closure of Michigan's ICF/MR system in the 1970s and 1980s. A few individuals with DD still reside unnecessarily in nursing homes.

Michigan is now focusing on reducing the number and size of group homes, expanding the effective use of person centered planning, and making self-determination options genuinely available to every person in Michigan who qualifies for DD services.

Programs and Services

HCBS Programs

Michigan was one of the first states to implement a combined 1915(b) and (c) waiver, known as the Specialty Supports and Services Waiver, for people with developmental disabilities. An extensive array of community-based, developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of the waiver by an approved Prepaid Inpatient Health Plan (PIHP).

A PIHP must be certified by MDCH as a Community Mental Health Services Program (CMHSP) under the Michigan Mental Health Code. It must make available, either directly or through contract with other providers, both the comprehensive array of services specified under the Michigan Mental Health Code and all specialty services and supports approved in the waiver. This includes medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity. The array of supports available under the Specialty Services waiver is detailed in Table 4-1.

[44] See http://www.michigan.gov/mMDCH/0,1607,7-132-2941_4868_4897-14626--,00.html

Table 4-1 Services Available through the Specialty Services Waiver

1915(b)	1915(b)(3)	1915(c)
Assertive Community Treatment	Assistive Technology	Chore Services
Assessments	Community Living Supports	Community Living Supports
Behavioral Management Review	Crisis Observation Care	Enhanced medical equipment and supplies
Child Therapy	Drop-in Centers	
Clubhouse Psychosocial Rehabilitation Programs	Enhanced Pharmacy	Enhanced pharmacy
Crisis Intervention	Environmental Modifications	Environmental modifications
Crisis Residential Services	Family Support and Training	Family training
Family Therapy	Fiscal Intermediary Services	
Health Services	Housing Assistance	Out-of-home non-vocational habilitation
Home-based Services	Peer Delivered or Operated Support Services	Pre-vocational services
Individual/Group Therapy	Peer Specialist Services	Private duty nursing
Intensive Crisis Stabilization Services	Prevention-Direct Service Models	Respite care
ICF/MR Services	Respite Care Services	Supports coordination
Medication Administration	Skill-building Assistance	Supported employment
Medication Review	Supported/Integrated Employment Services	Personal emergency response systems
Nursing facility mental health monitoring	Wraparound Services	
Occupational therapy	Supports and service coordination	
Personal care in licensed specialized residential settings	Substance abuse treatment services	
Physical Therapy		
Speech, hearing, and language		
Substance abuse		
Targeted case management		
Telemedicine		
Transportation		
Treatment planning		

People receiving specialty supports and services from a PIHP may also be simultaneously enrolled in a Medicaid health plan for acute and primary care, and are eligible for all other State Plan services as well.

Non-HCBS Programs

Michigan has dramatically reduced use of ICF/MR since its peak use in the early 1970s. The one remaining facility, currently housing fewer than 60 residents, is due to close October 2009. It is expected that most all of the people with DD still residing there will be in a community setting by the beginning of calendar year 2010.

Demographic and Utilization Trends

The number of people with a diagnosis of DD only and receiving supports and services dropped slightly from 2005 to 2007.[45] However, individuals with diagnoses which qualify them both under developmental disability criteria and serious mental illness increased during the period, due to increased efforts by PIHPs to identify such individuals. Therefore, it is reasonable to conclude that the specialty waiver is serving essentially the same population over these three years with a slight increase likely due to the overall increase of Michigan's Medicaid eligibles.

Table 4-2 People Receiving DD Services 2005-2007

Fiscal Year	# People Receiving DD Services	# People with Qualifying Dual Diagnosis (DD and Serious MI)
2005	27,807	7,183
2006	27,036	9,470
2007	27,448	10,273

OBRA 1992 intended that individuals be served in the least restrictive and most appropriate setting. In Michigan, placements of people with DD into nursing facilities by CMHSPs is monitored by DCH, and is therefore is kept to a minimum. However, neither CMHSPs nor DCH have control over placements done by family members. As a result there are more individuals with DD in nursing facilities than is desired.

There is a population of individuals with DD minimally involved in support and service systems who have lived with family members for their entire life. These individuals are aging, as are their caregivers. When these caregivers die or become unable to provide continued care, there will be a need for support services from a population that has had little interaction with the service system. While some individuals in this situation are known and their needs anticipated by the CMHSPs, there are others who resist outreach, and still others who are completely unknown. It is possible this cohort will attempt to access their first services over a short period of years and will strain a system already having difficulty with its current service and support demands.

Approximately 20% of individuals with DD, served by the public mental health system, reside in licensed adult foster care settings. DCH is pursuing strategies to assist CMHSPs developing and finding smaller individualized options for them.

MDCH is attempting to address these and other issues related to communities of choice through its renewal and re-commitment initiative. FY 2010 goals focus on the community supports needs of people with developmental disabilities:[46]

[45] See http://www.michigan.gov/mMDCH/0,1607,7-132-2946_5080-14214--,00.html
[46] See http://www.michigan.gov/documents/mMDCH/Consultation_Draft_of_ARR10_03_08_1_251571_7.pdf

Components Associated with Rebalancing

Integrated Administration

MDCH is responsible for assuring integrated administration and strategic planning for all health services, reporting requirements, and prevention program implementation. In theory, people receiving supports for developmental disabilities, serious mental illness, and substance abuse disorders can receive integrated supports regardless of their individual characteristics. For the past four years MMDCH has made considerable effort to provide training and technical assistance to CMHSPs to improve their practice of integrating supports supports across diagnostic categories. There have been some local successes, but depending upon the locale it can still be difficult for a person who needs supports across DD, MI, and SA services to receive genuinely integrated supports planning and implementation. Of emerging concern are the Michigan veterans, who qualify as people with DD by virtue of their age when wounded, return to their homes with Post Traumatic Stress Disorder and other mental health issues, and substance abuse problems.

Single Access Point

Access points to the Medicaid Specialty Supports and Services Waiver varies by region. In some PIHPs there is a central access center that serves all counties in its affiliation. In other cases, the each CMHSP in the affiliation serves as the single access point.

There is a movement toward standardizing access regardless of how it is conducted (in person, by phone, on-line). Training and technical assistance, including guidelines and standards, is being provided to PIHPs to implement systems that ensure uniform access to supports and services. This is in addition to a current statewide effort to make health information and records inputs and use seamless statewide.

Institutional Supply Controls

The Michigan mental health system has had a long and successful history of deinstitutionalizing its DD population. Its one remaining ICF/MR is scheduled to close in the current fiscal year. Effort is needed to ensure that Michigan continues to develop and grow a range of options for living that promote the ability of people with DD to have control over all aspects of their lives.

Transition from Institutions

The one remaining Michigan facility at present has fewer than 60 residents under the ICF/MR state plan service. The person-centered planning process is being used to arrange the necessary supports and services through the Specialty Supports and Service Waiver, and the Habilitation Supports Waiver that will ensure a successful community experience.

There are approximately 30 additional people with developmental disabilities and co-occuring serious mental illness at the facility, housed there because of their individual statuses in criminal cases, such as not-guilty-by-reason-of-insanity, unable to assist in their defense, and similar categories of legal "incompetence." Since MMDCH cannot unilaterally move these individuals into

the community (each requires a probate or other jurisdictional court to rule on any change in placement), it has established a specialized unit in another facility, at the same time it has begun working with the courts that have jurisdiction over these individuals and the home CMH of each to customize a community placement which meets both the court security requirements and individual support needs through a modified person-centered planning process.

Continuum of Residential Options

Michigan's residential options include the small and closing ICF/MR program, various sizes of licensed foster care settings, supported independence programs, and supports to individuals who rent or own apartments, condominiums, and single family homes. Michigan has evolved from referring to residential arrangements as "a continuum" to supporting people with DD in places of their own choosing, where they can control who walks in the front door, who (if anybody) their roommate is, and who delivers the supports. It is the belief in Michigan that the range of options available should reflect the free choice of individuals receiving supports, and that over time, these choices will result in the majority of people with DD renting an apartment or owning a home, as is the case for people without DD.

Building Infrastructure

Expanding the HCBS infrastructure in Michigan will follow the course set over the last decade as well as values first developed and implemented in Michigan in the late 1970s:

- Person-centered planning is the way people's desired outcomes and needs for support are identified. Self-determination with or without personal budget control is a universally available option within person-centered planning. This system of making personal choice the signature event in the delivery of supports will drive provider organization and services and PIHP funding priorities.
- Expansion of the "community" part of community-based services to include collaborative systems of support across all available resources in a given geographic region
- The inclusion of people with developmental disabilities who have elderly parents and who at present do not receive supports from the Specialty Supports and Services Waiver or the Habilitation Supports Waiver in this coherent community support system.
- The continued movement away from residential option-determined supports to supports delivered based on need and without regard for residential location, under the person's effective control.
- The development of peer-to-peer services among those people with developmental disabilities receiving support under the Specialty Supports and Services Waiver.
- The creation of truly integrated supports for people who have DD and other disability characteristics, such as emotional disturbance, brain-injury, and substance abuse problems.

These themes are all extensions of work being done now and will be the true measure of the success of a community-based supports system for people with developmental disabilities.

Participant Direction

Person-centered planning (PCP) became a requirement for all mental health services in Michigan through a change in the Michigan Mental Health code in 1996.

MDCH has focused on providing person-centered planning[47] for people with developmental disabilities for a number of years. With the use of federal grants, the movement of the DD population to participant direction has gained momentum. Self-determination projects were originally funded by a Robert Woods Johnson Foundation grant, but at present are sustained by other funding sources. The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a PCP process regardless of age, disability, or residential setting.

Self-determination embodies a set of concepts and values stating that individuals receiving services from the public health system have the right to define their lives and the public mental health system should support them in doing so. Michigan's Self-Determination Policy and Practice Guideline provides guidance to PIHPs and CMHSPs so participants in concert with their allies may be successfully guided and supported in achieving arrangements that support self-determination. In order to encourage and support increased opportunities for more individuals to choose a self-determination arrangement, the MMDCH recently published the "Choice Voucher System Self-Determination Technical Advisory Version 2.0."[48] The MMDCH will continue to provide support and guidance to CMHSPs and PIHPs to ensure expansion in the use of self-determination arrangements continues. The "Self-Determination Policy and Practice Guideline"[49] was issued by DCH in July, 2003 to direct CMHSPs in providing person-centered services. DCH continues to monitor and provide feedback and training to CMHSPs with regard to PCP and family-centered practice.

Quality Management

Quality management policies are included in the CMS-approved 1915(b) and 1915(c) waivers and the individual contracts between DCH and the CMHPS.

Summary

Michigan has come a long way since the 1970s in assuring choice and community for people with DD. A number of goals remain from the 1970s, including the closing of Michigan's only remaining ICF/MR institution, an effort which is currently underway. In moving forward, Michigan must build on its promise of choice and control to all people with DD by expanding the use of self-determination; continuing the move from group homes to apartments and home ownership; and expanding collaboration with other community services and supports so that there are more opportunities for, and information about, true community inclusion and participation, independence and productivity.

[47] MMDCH Specialty Prepaid Health Plan, 2002 Application for Participation.
[48] See http://www.michigan.gov/documents/mMDCH/Choice_Voucher_System_Transmittal_9_30_08_251403_7.pdf
[49] Self-Determination Policy and Practice Guidelines issued July 18, 2003.

SECTION 5: PEOPLE WITH MENTAL ILLNESS

Mental illnesses are conditions that disrupt a person's thinking, feeling, mood, the ability to relate to others, and daily functioning, and often result in a diminished capacity for coping with the ordinary demands of life. Serious mental illnesses include depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.

Mental illnesses can affect people of any age, race, religion, or income. They are not the result of personal weakness, lack of character, or poor upbringing. Mental illnesses are treatable and people with mental illness can and do recover. In addition to medication, psychosocial treatment such as cognitive behavioral therapy, interpersonal therapy, peer support groups, and other community services can be components of a treatment plan to assist in recovery. The availability of transportation, diet, exercise, sleep, friends, and meaningful paid or volunteer activities contribute to overall health and wellness, including mental illness recovery.[50]

Because mental illness is not a short-term issue, medication and psychosocial treatment are not short-term services. The role state long-term care can play in providing these services is vital to individual long-term recovery.

Like people with developmental disabilities, individuals with mental illness receive their mental health services through the local Community Mental Health Services Plan (CMHSP), and if they are Medicaid enrollees, under the umbrella of a Prepaid Inpatient Health Plan (PIHP) which provides Medicaid-funded mental health services through a prepaid managed care 1915(b) waiver. Consumers whose needs do not render them eligible for PIHP specialty services and supports receive their outpatient mental health services through the fee-for-service Medicaid program or a Medicaid health plan. The CMHSPs receive limited funding for non-Medicaid services from state general funds and are able to serve a small number of people with the most serious forms of mental illness and who are not Medicaid eligible.

At present, Michigan is undergoing a system transformation effort to reconfigure supports for people with serious mental illness using the model of recovery. The principles of recovery require genuine respect for the decisions, hopes, and dreams of the person receiving support. While medication has its place in recovery, the medical model does not dictate the form or planning of the recovery process. Rather, the person going through recovery directs the process.[51]

Programs and Services

HCBS Programs

People with mental illness in Michigan are served under the same Medicaid Specialty Supports and Services waiver in place for the DD population. Like those with DD, people with serious mental illness receive services through a regional Prepaid Inpatient Health Plan (PIHP). Services available under the PIHP are detailed in Section 4.

Some may also be enrolled in a Medicaid health plan for their acute and primary care.

[50] http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm
[51] http://www.michigan.gov/documents/mMDCH/Attachment_3.System_of_Care_Feb_2008_225705_7.pdf

Non-HCBS Programs

Approximately 10.65% of individuals with serious mental illness served by the public mental health system live in adult foster care and nursing facilities, or temporarily reside in state institutions or prisons. Private inpatient mental health facilities remain an expensive (especially since Medicaid funds cannot be used to provide supports in these hospitals) and largely coercive system. While the number of people who receive services in these institutions is small, the resources expended on them are considerable. The use of non-Medicaid funds for this purpose reduces the state contribution available to match Medicaid and undermines the availability of state funds for people who have serious mental illnesses but are not eligible for Medicaid.

Demographic and Utilization Trends

The number of people with serious mental illness who are receiving supports and services from the public mental health system increased by 5% from 2005 to 2007. The growth is believed to be a result of increased Medicaid eligibles in Michigan and also efforts by PIHPs to identify such individuals.

Table 5-1 People Receiving Supports for Serious MI 2005-2007[52]

Fiscal Year	# People Receiving Supports for Serious MI	# People with Qualifying Dual Diagnosis (DD and Serious MI)
2005	158,412	7,183
2006	163,546	9,470
2007	166,524	10,273

Approximately 60% of people with serious mental illness are eligible for public funding program such as Medicaid. Despite OBRA, 3,325 people with serious mental illness remain in nursing facilities.

DCH is addressing these and other issues related to expanding communities of choice through its renewal and recommitment initiative. For FY 2010, goals focus on the community supports needs of people with serious mental illness.

Components Associated with Rebalancing

Integrated Administration

DCH is responsible for assuring integrated administration and strategic planning for all health services, reporting requirements, and prevention program implementation. In theory, people receiving supports for developmental disabilities, serious mental illness, and substance abuse disorders can receive integrated supports regardless of their individual characteristics. Over the past four years DCH has undertaken a major initiative to provide training and technical assistance to CMHSPs to develop local integration of supports and services for people with co-occurring serious mental illness and substance use disorders. There have been local successes, but much work remains to be done before people can receive genuinely integrated supports and services.

[52] Fingertip Report , Summary Statistics for Michigan's Public Mental Health System

Single Access Point

Access points to the Medicaid Specialty Supports and Services Waiver vary by region. In some PIHPs there is a central access center that serves all counties in its affiliation. In other cases, each CMHSP in the affiliation serves as the single access point.

There is a movement toward standardizing access regardless of how it is conducted (in person, by phone, on-line). Training and technical assistance, including guidelines and standards, is being provided to PIHPs to implement systems that ensure uniform access to supports and services. This is in addition to a current statewide effort to make health information and records inputs and use seamless statewide.

Institutional Supply Controls

Michigan has a long and successful history of deinstitutionalization, including people with serious mental illness and children with serious emotional disturbance.. The Mental Health Code requires that services be provided in the least restrictive environment. Beginning in the 1980's the State began placing a greater emphasis on supporting people with serious mental illness in community settings. More people began receiving services in the community as the state closed its inpatient care facilities. CMHSPs are required by contract to ensure this goal is met.

Transition from Institutions

Other than transitions that are facilitated through the person centered planning process, there is no formal initiative focused on transitioning individuals with mental illness from institutional to community settings.

Continuum of Residential Options

Michigan provides supports and services in a range of settings for people with mental illness. Its policy is to support people with mental illnesses in places of their own choosing, where they control who, if anyone, is a roommate, what supports are provided, and by whom they are delivered. Over time this policy has resulted in the majority of people with mental illness renting an apartment or owning a home, as is the case for people without mental illness.

Building HCBS Infrastructure

Expanding the HCBS infrastructure in Michigan will follow the course set over the last decade as well as values first developed and implemented in Michigan in the late 1970s:

- Person-centered planning is the way people's preferred outcomes and needs for supports are identified. Self-determination with, or without, personal budget control is a universally available option within person-centered planning, although little-utilized. This system of making personal choice the signature event in the delivery of supports will drive provider organization and services and PIHP funding priorities.
- Expansion of the "community" part of community-based services to include collaborative systems of support across all available resources in a given geographic region.
- The inclusion of people with mental illness who currently do not receive supports from the Specialty Supports and Services Waiver in this coherent community support system.

- The continued movement away from residential option-determined supports to supports delivered based on need and without regard for residential location, under the person's effective control.
- The development of peer-to-peer services among those people with mental illness and implementation of recovery models.
- The creation of truly integrated supports for people who have multiple disability characteristics.

These themes are all extensions of work being done now and will be the true measure of the success of a community-based supports system for people with mental illness.

Participant Direction

Person-centered planning (PCP) became a requirement for all mental health services in Michigan through a change in the Michigan Mental Health statute in 1996.

As previously described in Section 4, pages 34-35, DCH focused on providing person-centered planning for people with developmental disabilities for a number of years prior to 1996. Since 1996, when person-centered planning was mandated for all people receiving public mental health services, MMDCH has focused on assuring that people with serious mental illness not only have access to PCP but also self-determination arrangements. This movement has been enabled and enhanced by the use of federal grants.

Self-determination embodies a set of concepts and values stating that individuals receiving services from the public mental health system have the right to define their lives and should receive support in doing so. MMDCH provides support and guidance to CMHSPs to ensure expansion in the use of self-determination arrangements. The recovery initiative is helping to accelerate the acceptance of PCP and self-determination.

Quality Management

Quality management policies are included in the CMS-approved 1915(b) and 1915(c) waivers and the individual contracts between MDCH and the CMHPS.

In FY 2010, MDCH will implement the Recovery Enhancing Environment (REE) measure throughout Michigan's CMH system. This measure focuses on how welcoming and effective the support system environment is in securing recovery outcomes by using the experience of people receiving supports. The assessment tool measures how well integrated recovery is into a variety of support services, how deep the local understanding of recovery is, and provides summary data for planning and training use. Surveyors will be peers (e.g., people with serious mental illness who are trained and certified as peer support specialists) from other geographic areas of the state.

Summary

Michigan is on the cusp of dramatically changing the way people with serious mental illness are viewed both within the system and in the external community, and the way these people are supported to live self-determined lives where they wish.

The key to this transformation is the internalization of the principles of recovery by every person who uses the system, and every professional and supports provider receiving funding from the public mental health system. When recovery is implemented as the driving principle of mental health services in Michigan, people with mental illness will achieve the goals of home and community-based service: the freedom to live personally defined lives of choice and quality.

SECTION 6: SERVICES FOR CHILDREN

Services for children are administered across three State of Michigan entities: the Department of Community Health (DCH), the Department of Human Services (DHS), and the Department of Education (DOE). The DCH Mental Health and Substance Abuse Administration funds services for children with developmental disabilities and/or mental illness. The DHS administers the Children's Foster Care Program and Children's Foster Care licensure. The DOE is responsible for educating children from age 0 to 26 in Michigan. Schools must provide the variety of therapies and behavior management as Medicaid and Title V are the primary payers for long-term care services delivered to children in Michigan.

Michigan's array of programs for children operates independently from each other and opportunities exist for streamlining. There are no single points of entry for children's services. Consistent protocols for transitioning children to adult long term care supports and services programs do not exist.

Programs and Services

HCBS Programs

Habilitation Supports Waiver for Persons with DD (HSW)

Beneficiaries with DD, including children, may be enrolled in Michigan's HSW and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional Section b(3) services. A HSW participant must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria are used to determine the amount, duration, and scope of services and supports to be used. Services and supports that are to be provided under the auspices of the PIHP must be specified in an individual plan of services developed through the person-centered planning process. The HSW is part of the 1915(b)(c) Mental Health Managed Care Waiver.

Children's Waiver (CWP)

The CWP is designed to provide in-home services and supports to eligible children up to age 18 who have a developmental disability, meet the criteria for placement in an ICF/MR, and who would otherwise be at risk for out of home placement. It is administered by the DCH Mental Health Services for Children and Families Division, and implemented through local CMHSP agencies under a 1915(c) waiver. This waiver allows for created Medicaid eligibility. For the purpose of this waiver, a child is considered a family of one, making the CWP accessible to families who would not otherwise qualify financially for Medicaid. Michigan has approval to serve 464 children to receive services from the CWP. This waiver is a fee-for-service waiver.

Waiver for Children with Serious Emotional Disturbance (SEDW)

Children with serious emotional disturbance are provided services under this 1915(c) waiver. The SEDW is designed to provide in-home services and supports to eligible children up to age 18 who have a serious emotional disturbance and meet the admission criteria for the state's psychiatric hospital for children. Michigan currently has approval for up to 79 children in 13 counties to receive services from the SEDW. This waiver allows for created Medicaid eligibility. For the purpose of this waiver, a child is considered a family of one, making the SEDW accessible to families who would not otherwise qualify financially for Medicaid. The state match for services provided under this waiver is provided by the local CMHSPs. The SEDW is a fee-for-service waiver.

Family Support Subsidy Program

The Michigan Legislature passed the Family Support Subsidy Act in 1983. The Department of Community Health and the CMHSPs administer and implement the act. Together, they are supporting families to keep their children at home.

The Family Support Subsidy (FSS) Program is administered through the Department of Community Health, Bureau of Mental Health and Substance Abuse Services, Division of Mental Health Services to Children and Families and provides financial assistance to families that have a child with serious developmental disabilities. The intent is to help make it possible for children with developmental disabilities, from birth to age 18, to remain with, or return to, their birth or adoptive families. The program provides a monthly payment of $222.11 per child. Families are able to use this money for special expenses incurred while caring for their child.

Uses for the subsidy dollars might be the purchase of additional therapies, special equipment, special food, paper diapers, transportation costs, in-home specialized care, respite care, family counseling, support groups, general household expenses, family recreation and home remodeling to provide for the special needs of the child. The unique feature of the subsidy is that the family decides its use to suit their needs in order to keep their family intact.

Children's Foster Care

Foster care is 24-hour substitute care for children between the ages of 1 and 21 placed away from their parents or guardians for reasons of abuse and neglect. The DHS Foster Care Program provides placement and supervision of children who are temporary or permanent wards.

The purpose of foster care is to provide safety, continuity, consistency, and permanency in a family setting for the growing child. If a return home is not possible, alternative permanency plans must be pursued. Current foster care policy directs the case worker to appropriate service delivery and timely permanency planning decisions. Independent living services must be provided to older youths to ensure a successful transition to adulthood once they exit the foster care system.

Table 6-1 below reflects the numbers of children in assistance programs that currently require, and are expected to continue to require, long-term care services. Their numbers will impact the adult long-term care system as they age out of children's programs and seek ongoing services and supports from various waiver programs.

Table 6-1 Statewide Special Needs of Foster Care Youth[53]

CALENDAR YEAR	EMOTIONALLY IMPARIED	MENTALLY IMPAIRED	OTHER MEDICALLY DIAGNOSED	PHYSICALLY DISABLED	VISUALLY IMPAIRED	HEARING IMPAIRED	SPECIFIC LEARNING DISABILITY	SPEECH AND LANGUAGE	YEAR TOATLS
2004	482	209	443	99	49	35	326	223	1876
2005	450	165	405	68	44	230	298	213	1666
2006	403	175	483	92	57	52	287	267	1816
2007	366	154	408	820	47	31	296	239	1623
2008	590	150	318	69	40	260	207	158	1258

Note: Unduplicated count based on the year that foster care case was accepted. 2008 is incomplete at the time of this report.

[53] Department of Community Health, Child Foster Care Unit

Special Education

Education services are a universal benefit mandated under the federal Individuals with Disabilities Education Act (IDEA). In Michigan, students are served in special education programs through the age of 26. The education system also manages federal and state-funded early intervention grants for children age three to five and coordinates an intervention system for infants and toddlers called Early On®Michigan. Referrals to Early On® come from a variety of sources such as families, doctors, hospitals, other health care providers, parent groups, and others. Although not all children in special education programs will need long-term care services as adults, we can look to specific educational categories, (cognitive, severely multiply impaired, autism, and emotionally impaired) for trends that might predict a need for future services.

Project Find is a mandated project, funded by the Michigan Department of Education, Office of Special Education and Early Intervention Services. Project Find conducts continuous public awareness and referral activities designed to locate, identify, and refer as early as possible all children, youth, and young adults with disabilities who may be eligible for special educational services through Michigan's Administrative Rules for Special Education and the Individuals with Disabilities Education Act Part B. Project Find is devoted to helping individuals, parents, and people who work with families (known as primary referral sources), to connect with the special educational services that may be needed. In Michigan, eligible children, youth, and young adults may receive special educational services from birth to age 26.

Non-HCBS Programs

Although there are no state run institutions for children in Michigan, the DHS Bureau of Child and Adult Licensing reports 194 active private Child Care Institutions (CCI) licensed for 1 to 500 beds. Although, no CCI exists in Michigan that has 500 beds, there are a few with up to 200 beds. These CCIs are not prohibited from using restraints and seclusion; hence, they are not funded with Medicaid, but funded with other federal and state funds. There is no requirement for accreditation, but most are accredited by the Council on Accreditation. The focus of these institutions is on youth in the juvenile justice system, a huge majority of who have mental health issues.[54]

Michigan continues to operate one state psychiatric hospital for children known, the Hawthorn Center. If a local CMH authorizes psychiatric hospitalization for a child with Medicaid, the child will be referred to either a community psychiatric hospital or the Hawthorn Center. Because the state does not fund large CCIs with Medicaid dollars, the CMH system rarely places a child in that setting.

Demographic and Utilization Trends

Data is collected and reported by each individual department/office. Depending on their needs, children can be enrolled in multiple programs at the same time.

Table 6-2 Children's Waiver Program
Enrollment and Expenditures 2005-2007

Year	Number Enrolled	Expenditures
2005		$18,767,498
2006	428	$16,390,218
2007	457	$22,179,124

[54] Bureau Information Tracking System; Bureau of Child and Adult Licensing, Michigan Department of Human Services.

Table 6-3 Family Support Subsidy Enrollment and Expenditures 2005-2008[55]

Year	Number Enrolled	Expenditures
2005	6,675	$17,033,010
2006	6,722	$17,564,819
2007	6,832	$17,864,678
2008	6,934	$18,030,899

Table 6-4 Special Education Pupils by Disability[56]

Category	Headcount by Disability	
	2005-06	2006-07
Cognitive Impairment	27,175	26,560
Emotional Impairment	19,178	18,128
Learning Disability	94,763	92,635
Hearing Impairment	3,363	3,375
Visual Impairment	951	992
Physical and Other Health Impairment	23,032	23,552
Severe Multiple Impairment	4,073	4,123
Early Childhood Special Education Program	6,257	6,433
Severe Language Impairment		
Autistic Impairment	10,133	11,366
Resource Room		
Early Childhood Special Education Services		
Traumatic Brain Injured	582	626
Speech and Language Impaired	61,253	61,208
Deaf/blind	9	8
TOTALS - K12 & ISD Special Education	250,769	249,006

Table 6-4 demonstrates the potential of children who currently require long-term care services and could age into the adult services component at the age of 26.

Components Associated with Rebalancing

Streamlined HCBS Administration

Michigan does not have a single designated entity specific to children's long-term care services. There are three state level departments administering services and programs specific to children: the Department of Community Health, the Department of Human Services (DHS), and the Department of Education. Within MDCH, the Public Health Administration and the Mental Health and Substance Abuse Administration coordinate programs for specific populations of children. The Medical Services Administration (MSA), also in MDCH, supports many of the programs with Medicaid funds. Coordination between programs occurs at collaborative tables or workgroups that are issue specific and through professional relationships, both historical and personal.

[55] Ibid
[56] http://www.michigan.gov/documents/mde/1968-2007PupilCountData_234340_7.pdf

The various programs discussed in this section are implemented by local level equivalents of the state level departments, including local and intermediate school districts, CMHSPs, and county public health programs.

Currently all counties, either individually or in cooperation with others, have an established community collaborative group that addresses issues that impact the lives of children, families, and special populations in their area. The strength of the community collaboratives varies, however Michigan is one of the few states that has community collaboratives statewide and that are supported by the state human services directors. Also, through the Early Childhood Investment Corporation, Great Start Collaboratives have been established statewide to focus specifically on developing systems of care for children birth to six and their families.

Single Access Point

There is no single access point for children's services in Michigan. Referral to available programs occurs through a variety of sources: education, the medical community, public health agencies, the courts, Child Find for both Part C & Part B, and personal network referral. Coordination of programs is occurring on a county level basis through a variety of mechanisms as discussed earlier. In addition Michigan has established a 211 System that covers 72% of the population and will be statewide in two years. It provides information to any caller on how to access services.

Institutional Supply Controls

There are over 17,000 children in 6,080 foster care homes licensed for 1 to 4 children, and 309 foster care homes licensed for 5 to 6 children. In December 2008, the Michigan legislature created an additional licensing category – Children Therapeutic Group Home – that prohibits restraint and seclusion and is funded with Medicaid dollars. Currently, there is one 6-bed group home licensed under this new category.[57]

These numbers are significant because foster children are much more likely than other children to have a disability. [58]

Transition from Institutions

The two service systems that utilize institutions and group homes, CMH and DHS, do not share a consistent philosophy or statewide methodology to transition children to less restrictive settings. Transitions are often dependent on the advocacy efforts of family members and case workers. There is a smaller ratio of children to caseworkers in the CMH system than in the larger DHS children's services system, although, as part of the DHS Children's Rights Lawsuit and settlement, caseload ratios are being set.

Each service system has its own procedures for transition from the children's service system to the adult service system. Someone aging out of a children's program may not necessarily qualify for services in the adult mental health system, and if they do qualify, the adult mental health services system is oftentimes not geared for providing services to young adults. The DHS system too often directs youth to filling out forms for SSI and Medicaid, but fails to follow-up to determine that action has been taken. Special education services begin the transition from school process at age 16, providing some students with up to 10 years to develop skills of independent living before aging

[57] Bureau Information Tracking System; Bureau of Child and Adult Licensing, Michigan Department of Human Services
[58] O'Hare, William, Working Paper: Data on Children in Foster Care from Census Bureau, Kids Count Project - Annie E. Casey Foundation.

out of the program. The ability to move from school to employment may depend on the relationship between the local school system and Michigan Rehabilitation Services (MRS). The quality of the job search varies from counselor to counselor.

Continuum of Residential Options

The juvenile justice sector (courts and DHS) often places children in congregate care because of a lack of alternative intensive community-based services. Although, there are a number of communities where the CMH system, the courts, and the DHS systems are working together, other communities work independently of one another and funding and contracting barriers prevent the ability to easily merge their resources to provide coherent alternative services. A DHS Child Welfare Task Force and the recent DHS Children's Rights Settlement may help to remedy this situation.

Without a coherent system of community support, the schools too often are faced with a dilemma of children and families who are struggling with extreme behavior issues. If the child does not qualify for CMH services and if families have no private insurance, sometimes they are encouraged to give up their parental rights through a petition in family courts. When a child becomes a ward of the court, the child enters the DHS service system and is assigned to either a foster care home, a private child care institution, or in extreme cases, a juvenile justice facility.

Families with personal resources (including insurance) may seek an out of state placement. DHS tracks children who they place in an out of state institution but has no method of tracking private out of state placements.

Building Infrastructure

On July 3, 2008, the Director of the Department of Human Services announced a historic settlement with Children's Rights Inc. that resolved a federal lawsuit over Michigan's child welfare system. The agreement will build upon reform efforts already underway, improve safety for children and provide stronger support for those who care for them. In the end, children will have more promising outcomes. Key components of the agreement - that affects child welfare staff and agencies in both DHS and its private sector partners - include:

- Reduce caseload levels that could result in as many as 700 new staff dedicated to children's services over the next five years in the public and private sectors.
- Increase emphasis on prevention and family preservation.
- Step up timelines and increased resources to achieve permanency.
- Increase capacity by licensing relative and non-relative placements.
- Immediate identification of all children in need of a permanency plan and priority to those awaiting adoption for over a year.
- Revise DHS management structure that elevates children's welfare and provides greater support and oversight for front line staff.
- Establish a position of medical director overseeing policies related to medications and medical services for children under DHS care.
- Increase education and training requirements for children's service specialists and managers.
- Create a new DHS Quality Assurance Unit to evaluate and make recommendations to improve child welfare policies, procedures and services.

Participant Direction

The Choice Voucher System is one option for implementing arrangements that support self-determination. Although children can not self determine, the Choice Voucher System may be used by children and their families using mental health services, The elements of the system have been designed to meet the requirements of the Medicaid program, including the requirements of the Freedom of Choice (1915(b)) waiver, the Habilitation Supports Waiver, the CWP, and the Michigan Mental Health Code. The Choice Voucher System components make consumer/parent control possible by creating mechanisms to maintain PIHP/CMHSP accountability for service delivery and the use of public funds, particularly Medicaid funds,

Quality Management

Each system has its own system of quality management. Within DCH, the Bureau of CMH Services, Division of Quality Management and Planning (QMP) provides monitoring at all PIHP/CMHSPs. This review includes all services to adults and children (including children enrolled in the CWP and the SEDW) served in Michigan's mental health system. On-site reviews by the QMP staff focus on assuring quality, health and welfare, and the satisfaction of the consumers receiving services. Full on-site reviews are completed every other year. The review process includes: review of administrative policies and processes; review of a sample of clinical case records and other documentation; a meeting with the PIHP consumer panel; on-site visits to selected program locations; and interviews with individuals and/or family members.

The site reviews also assess the PIHP/CMHSPs and its providers for compliance with the standards contained in the Medicaid Provider Manual regarding Prepaid Inpatient Health Plans. In addition to the provider and program requirements specified in the Medicaid Provider Manual, the site review process looks at the adequacy and appropriateness of the individual's plan of service (IPOS), and of the persons staffing it. This includes the preparation, timeliness, and frequency of service planning meetings and professional monitoring, and the degree to which Waiver service consumers' choices, preferences, and needs are an integral part of planning.

The QMP staff conducts a follow-up site visit approximately one year after the full review is completed. During the follow-up visit, review team members evaluate the effectiveness of the PIHP's corrective action plan in correcting the deficiencies noted in the site review survey report.

Provider monitoring activities are conducted by the QMP staff and assess enrolled providers against the standards detailed in Michigan's Medicaid Provider Manual regarding mental health clinics. While the services and supports covered under the CWP are not an explicit focus of these reviews, the quality and integration of CWP services with the other services in the consumer's IPOS are enforced through the process. Items reviewed include but are not limited to: the qualification of the staff employed by the provider; the adequacy and appropriateness of the individuals and the persons staffing it; the preparation, timeliness and frequency of service planning meetings and professional monitoring visits; and the degree to which the consumer's choices, preferences, and needs are an integral part of the planning using a person-centered planning, family-centered practice process.

The QMP staff also conducts on-site reviews every three years of CMHSPs administering the CWP. This review samples active CWP cases and provides a detailed review of the CWP requirements. The site review provides an opportunity to provide technical assistance to CMHSPs. The CWP review standards include evidence of a safe and appropriate IPOS, waiver eligibility requirements, freedom of choice, service provider qualifications and contracts, administrative procedures, and Medicaid billings. This is accomplished through a review of clinical

records and staff and consumer interviews, using a CWP Review Protocol. During those years when a CWP site review is not required/provided the QMP staff conducts either a follow-up site visit approximately one year after the full review is completed or a full review (as indicated). During the follow-up visit, review team members evaluate the effectiveness of the CMHSP's corrective action plan in correcting the deficiencies noted in the first site review survey report.

The QMP/CWP provides a written survey report to the PIHP/CMHSP and the PIHP/CMHSPs are required to develop a written plan of correction to respond to each finding identified in the QMP site review survey report. The plan of correction must identify the actions to be taken and the time frames for completion of those actions. When the CWP staff completes an on-site review, the CMHSP is required to respond in the same manner described above. The QMP/CWP review and approve all plans of correction, indicating if additional actions need to be taken and the time frame for completion.

In those instances where the survey team determines that one or more individuals are not receiving appropriate and/or adequate treatment, or there is any serious hazard to the health and safety of individuals served by the provider, the survey team meets with the executive director of the CMHSP or with the recipient rights officer. In addition, the MDCH contract manager is responsible for following up with the CMHSP to ensure that corrective action takes place. This may occur at multiple times prior to the next scheduled survey by the review team.

The DCH staff working with SEDW conducts on-site reviews of CMHSPs administering the SEDW. This review samples active SEDW cases and provides a detailed review of the SEDW requirements. The site review provides an opportunity to provide technical assistance to CMHSPs. The SEDW review standards include level of care determinations and eligibility, Wraparound planning (regarding strategies or interventions and measurable outcomes), crisis and safety planning, consumer satisfaction, health and welfare, freedom of choice, strength and culture discovery, needs assessment across life domain areas, transition planning, service provider qualifications, contract arrangements for service providers, and Medicaid billings. This is accomplished through a review of clinical records and staff and consumer interviews in the family's home, using a SEDW Review Protocol and the Wraparound Fidelity to the Model worksheet.

The SEDW staff provides a written survey report to the CMHSP and the CMHSPs are required to develop a written plan of correction to respond to each finding identified in the SEDW site review survey report. The plan of correction must identify the actions to be taken and the time frames for completion of those actions. The SEDW staff review and approve all plans of correction, indicating if additional actions need to be taken and the time frame for completion.

On-going technical assistance and training is provided by DCH staff to PIHP/CMHSP staff to ensure quality improvement.

Michigan's work with children with serious emotional disturbances has received federal recognition for measuring outcomes through the level of functioning project, which uses the Child and Adolescent Functional Assessment Tool (CAFAS) to measure improvements for children, and for using the data to select evidenced based treatment to achieve better outcomes. CMH programs serving children with SED must be certified by MDCH as meeting the Children's Diagnostic and Treatment Service Administrative Rules Part 2 Subpart 6. These rules outline requirements for evaluation and screening, referrals, range of services, staffing and training, administration and the certification process itself which is done by MDCH.

Summary

Currently Michigan has several projects in place to address unmet needs for access to mental health services for children in child welfare and juvenile justice. For example, the CMHSP and Juvenile Justice systems, in a number of communities, are using a standardized tool, the MAYSI, to screen children for mental health issues and when appropriate providing mental health treatment thereby diverting them from the juvenile justice system. Michigan has also added additional funds to the PIHP/CMHSPs capitation rates for children and has set performance targets for the PIHP/CMHSPs to increase access for children and specifically to increase access to mental health services for children in child welfare and juvenile justice. DHS and MDCH are in discussion regarding the requirements of the DHS Children's Rights Settlement and opportunities for improved mental health services for children in child welfare.

A recent directive (February 2009) from MDCH Director of Mental Health Services[59] charges the local CMHSP agencies to take the lead the development of a comprehensive and interconnected network that will accomplish better outcomes for children with developmental disabilities and/or who have serious mental health disturbance. The directive acknowledges the lack of coordination between mental health, education, child welfare, juvenile justice and other service/supports providers in the community and calls for local stakeholders of all sectors that serve children to:

- assess the current array of services available,
- identify needs for service enhancement/improvement,
- develop potential strategies to improve the array of mental health services and supports in the community for children/youth and their families

Collaboration will be the first step taken to accomplish the goal of efficiency. Relationships built through collaboration offer the possibility of a unified commitment to serving our children in the community with a strong array of services.

[59] Michigan Department of Community Health, Mental Health and Substance Abuse Administration, Program Policy Guidelines for Community Mental Health Services Programs, February 1, 2009 and "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System", February 1, 2009.

SECTION 7: UNIQUE POPULATIONS

Veterans

Long-term care programs and services have an important role in the lives of veterans nationally and in Michigan.

In 2007, nationally about 5.5 million people were treated in Veterans Administration health care facilities and 3.6 million veterans and survivors received VA disability compensation or pensions. There were 761,000 veterans in Michigan in 2007; 11.45% of them received disability compensation or pension payments. For that same year, Michigan VA expenditures exceeded $1.65 billion, of which $810 million was spent on medical and insurance programs.[60]

The National Care Planning Council estimates approximately 22% of the U.S. population over age 65 are receiving some sort of long-term care assistance. Applying this percentage to the 9,348,000 veterans over the age of 65 presumes that upwards of 2 million veterans may be receiving some form of long-term care assistance. A limited number of these veterans may be receiving financial help from Veterans Affairs, but the majority of them are probably unaware of VA programs that are available to help pay the cost of long-term care.[61]

Eligibility for VA health care is dependent upon a number of variables, which may influence the final determination of service eligibility. These factors include the nature of a veteran's discharge from military service, length of service, VA adjudicated disabilities, income level, and available VA resources among others. Some veterans pay co-pays, and those with no service connected disability are a lower priority.

HCBS Programs

Veterans are eligible to participate in any Medicaid funded long-term care program for which they are functionally and financially eligible.

Under the VA, home and community-based services are available as a standard benefit to all veterans enrolled in the Home Based Primary Care program. Veterans must meet clinical need criteria and services must be ordered by a VA physician. In-home care is provided by VA staff to veterans with complex, chronic, disabling diseases for whom routine clinic-based care is not effective. The eligible veteran must require intermittent skilled nursing care and related medical services for a time-limited or a protracted period of time. The medical determination as to need for home health services is made by a VA Medical Center physician.

Skilled home care is provided by VA and contract agencies to veterans with chronic diseases, and includes nursing, physical/occupational therapy, and social services. The VA must offer skilled home care to a veteran if it is determined that a medical need exists.

The VA provides home hospice care to veterans that are diagnosed with a life-limiting illness, have treatment goals focused on comfort rather than cure, and are deemed by a VA physician to have a life expectancy of 6 months or less.

[60] US Department of Veteran Affairs.
[61] Day, Thomas. Veterans Aid and Attendance Pension Benefit Long-Term Care Benefits for Veterans. www.longtermcarelink.net.

Respite care services are personal care and supportive services delivered for the express purpose of temporarily relieving a caregiver. Respite care services are limited to 30 days per year from all settings. Services are prescribed by a VA physician.

Homemaker/home health aide services are personal care and related support services that enable frail or disabled veterans to live at home. Care providers must be trained, competency evaluated, and employed by a home health agency.

Adult day health care provides service to disabled veterans in a congregate setting. Services are delivered both in VA facilities and purchased at VA expense in non-VA facilities, and include social, medical and rehabilitation services.

Certain veterans and service members with service-connected disabilities may be entitled to a Specially Adapted Housing grant from VA to help build a new, specially- adapted house, to adapt a home they already own, or buy a house and modify it to meet their disability-related requirements. Eligible veterans who are temporarily residing in a home owned by a family member may also receive a grant to help the veteran adapt the family member's home to meet his or her special needs.

The Veterans Health Administration, in partnership with the Administration on Aging, is rolling out a new veteran-directed home and community-based service program (VD-HCBS) that serves veterans of any age who are at risk of nursing home placement and their family caregivers. The VD-HCBS program provides veterans the opportunity to receive home and community-based services that enable them to avoid institutionalization and continue to live in their homes and communities. VD-HCBS will be offered as a service by 13 of the 16 Michigan area agencies on aging.

Non-HCBS Programs

The VA provides nursing facility services to veterans through three national programs. Each has its own specific admission and eligibility criteria.

- **VA Community Living Centers (formerly called VA Nursing Homes)**: VA-owned and operated nursing homes typically admit patients requiring short-term care, in need of placement for a service-connected disability, or those who have a 70% or greater service-connected disability. The Grand Rapids Home for Veterans has 618 nursing care beds and 140 domiciliary beds. The nursing care beds include 115 special needs beds with two 35-bed nursing units for the care of Alzheimer's dementia and one 45-bed nursing unit for dual diagnoses patients.

- **State Veterans' Home Program**: The state veterans' home programs are operated by the state. The state petitions the VA for a portion of construction grants and once granted, VA pays a portion of the per diem. States establish eligibility criteria for short and long-term care. Specialized services offered are dependent upon the capability of the home to render them. D.J. Jacobetti Home for Veterans in Marquette, MI has 182 nursing care beds, two infirmary beds, and 59 residential beds.

- **Community Nursing Home Program**: VA maintains contracts with community nursing homes through every VA medical center to meet the needs of veterans who require long-term nursing home care in their own community, close to their families.

Admission criteria requires that a resident must be medically stable, have sufficient functional deficits to require inpatient nursing home care, and be assessed by an appropriate medical provider to be in need of institutional nursing home care. In addition, the veteran must meet the required VA eligibility criteria for nursing home care or the contract nursing home program and the eligibility criteria for the specific state veteran's home.

Demographic and Utilization Trends

There are as estimated 742,221 veterans in Michigan. That number is projected to decrease by about 17% by the year 2016.[62]

The national trend in self-reported health status is a decreasing proportion reporting excellent or very good health as age increases, as shown in Table 7-1. For each age group, the largest proportion rated themselves as having excellent or very good health. The only exception was found among veterans age 75 or older, the largest proportion of whom rate their health as fair or poor (37.9 percent).

Table 7-1 Percent Distribution of Veterans by Health Status and Age[63]

	Total	Less than 35 years	35-44 years	45-54 years	55-64 years	65-74 years	75 years or older
Excellent	16.8	29.0	22.8	15.7	18.6	13.1	8.6
Very good	28.8	37.3	35.0	30.4	29.4	25.2	19.9
Good	30.1	23.6	28.6	31.7	27.5	32.4	33.3
Fair	16.3	8.6	10.2	14.2	15.8	19.7	25.4
Poor	7.9	1.5	3.2	7.9	8.6	9.5	12.5
Unknown	0.1	0.0	0.2*	0.1*	0.1*	0.1*	0.3*
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of veterans†	24,509,900	2,288,100	3,021,700	5,390,800	4,901,100	5,087,500	3,678,300

*Low precision and/or sample size for the denominator between 30 and 59.
†Estimates of number of veterans are rounded to the nearest hundred; the total estimate is larger than the sum of the groups because some veterans did not provide their age.
NOTE: This table excludes those veterans for whom there was a proxy respondent.

Table 7-2 on the following page displays age comparisons of health care received nationally in the past 12 months for two groups of veterans, those under age 65 and those age 65 or older. Across all health care types, proportionately more older veterans reported receiving such care, compared to younger veterans. The only exceptions to this are for psychiatric treatment or counseling and treatment for environmental hazard.

[62] Extracted from the U.S. Department of Veterans Affairs, Vet Population 2007, http://www1.va.gov/vetdata/page.cfm?pg=15
[63] National Survey of Veterans, 2001

Table 7-2 Percent Distribution of Veterans by Type of Care and Age[64]

	Total	Less than 65 years	65 +
Emergency room	23.4	22.4	25.3
Outpatient	74.1	70.6	79.9
Inpatient	14.3	10.3	21.0
Prescriptions	76.7	71.7	85.3
Treatment for environmental hazard	1.6	1.9	1.1
Psychiatric treatment/counseling	6.7	9.1	2.7
In-home health care	3.8	2.1	6.7
Prostheses	24.6	22.6	28.3
Number of veterans†	25,196,000	15,680,000	9,372,600

*Low precision and/or sample size for the denominator between 30 and 59.
†Estimates of number of veterans are rounded to the nearest hundred; the total estimate is larger than the sum of the groups because some veterans did not provide their age; percent estimates will not sum to 100 because veterans could indicate more than one type of health care.

Results of a comparison of veteran health benefits received in the past 12 months show that regardless of age, the proportion of veterans who use VA health care nationally only is very low, between 5.6 and 8.4 percent. The proportion of veterans using both VA and non-VA sources increases across age groups, except among those aged 55-64.

Table 7-3 Percent Distribution of Veterans by Source of Care and Age[65]

	Total	Less than 35 years	35-44 years	45-54 years	55-64 years	65-74 years	75 years or older
Use of VA health care only	7.4	6.0	5.6	8.4	7.6	8.1	6.9
Use of non-VA health care only	76.6	85.3	82.6	77.2	79.7	73.0	69.2
Use of both VA and non-VA health care	16.0	8.7	11.8	14.4	12.7	18.9	23.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of veterans†	22,223,200	1,755,000	2,452,900	4,638,800	4,410,600	4,919,800	3,933,500

† Estimates of number of veterans are rounded to the nearest hundred; the total estimate is larger than the sum of the groups because some veterans did not provide their age.
NOTE: This table includes only those who indicated they used some sort of health care in the last 12 months.

Components Associated with Rebalancing

Transition from Institutions

There is a need to increase efforts in the area of nursing facility transitions. The VA goal is to provide care in the least restrictive environment however they do not have a history of reaching out to veterans in nursing facilities to deinstitutionalize and transition them to community settings. VA has established a performance measure to increase their Home and Community Based Average Daily Census.

[64] Op Cit
[65] Op Cit

Participant Direction

As indicated earlier in this section, the Veterans Health Administration, in partnership with the Administration on Aging, is rolling out a new veteran-directed home and community-based service program (VD-HCBS) that serves veterans of any age who are at risk of nursing home placement and their family caregivers. Veterans will work with case managers to develop person-centered plans and assist in arranging self-directed services based on the needs and preferences of the participating veterans.

Summary

There are significant challenges and unmet needs for veterans who need long-term care services:

- Lack of knowledge among veterans as to available benefits and how to access them;
- Difficulty in accessing services due extensive bureaucracy;
- Initial services must be provided through a VA facility, not necessarily the nearest facility;
- Lack of enough direct services staff to provide services to a growing number of veterans;
- Difficulty in proving a disability is service-related;
- Not enough providers and facilities especially in rural areas; and
- Services are not person-centered.

Efforts to address these barriers and provide more person-centered HCBS will be made under the OSA Nursing Home Diversion partnership with the Veterans Administration.

Persons with Dementia

The impact of the growing prevalence of individuals with a dementia-causing disease on Michigan's long-term care infrastructure is significant. The wide range of costs include not only the direct care of the person with dementia but also the associated issues of the paid caregiver workforce, the informal (family and friends) caregivers, and the economic cost of their job loss.

It is estimated that approximately 200,000 people in Michigan have dementia.[66] In general, the percentage of people with Alzheimer's disease and related dementias doubles every five years after age 65. As many as half of people age 85 and over have Alzheimer's disease. With the increase in life expectancy and the aging of the baby boomer generation, the number of elderly persons with dementia is on the verge of burgeoning growth.

Many of these individuals will require some form of long-term care as the disease progresses. Given the high average cost of services (e.g., adult day center services - $64/day, assisted living - $36,372/year, and nursing facility care - $69,715 - $77,380/year[67]) none of these services is affordable for long for most people living with Alzheimer's or other dementias. Few individuals or families coping with dementia can afford to pay these costs without eventually getting help from governmental sources, primarily Medicaid.

Burden of Dementia

The personal toll of dementia on persons who have the condition and family caregivers cannot be calculated. They experience direct costs (medical care), indirect costs (such as lost wages from missed work), and the incalculable costs of emotional and physical pain and suffering. More than half of one group of family caregivers surveyed reported cutting back on work hours or giving up their jobs because of the demands of caregiving.[68]

The financial burden of dementia is enormous. Alzheimer's disease is the third most expensive disease in the United States. The economic impact of Alzheimer's disease and other dementias is greater than the cost of diabetes, stroke, or HIV/AIDS combined. The U.S. spends at least $100 billion a year on Alzheimer's disease, which translates to about $25,000 per person per year. Under the assumption that other types of dementia have similar costs, Michigan faces a financial burden for dementia of about $5 billion per year.

In addition to health care costs, dementia affects the economy through its impact on businesses. Many people who care for elderly loved ones also work full time. Conflicting work and caregiving demands lead to increased business costs. These costs are related to replacing workers who leave their jobs, workday interruptions, care recipient crises, partial and total absenteeism, and special demands on supervisor time. Nationally, the estimated indirect costs to business for employees who are caregivers of people with Alzheimer's and other dementias was $36.5 billion, calculated for 2002 and projected to 2005[69].

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[66] The Alzheimer's Association estimates that there are a combined 200,000 people in Michigan with Alzheimer's disease, the most common cause of dementia, Parkinson's disease, and Huntington's disease.
[67] Alzheimer's Association, 2009 Alzheimer's Disease Fact and Figures, p. 53.
[68] National Institutes on Health, National Institute on Aging. 11/17/08. http://www.nia.nih.gov/HealthInformation/Publications/endoflife/03_dementia.htm.htm
[69] Alzheimer's Association, Op. Cit., p. 48.

Programs and Services

Today, a range of programs and services in Michigan help to meet the needs of persons with dementia and their caregivers. Of particular note are the Michigan Dementia Coalition and state programs specifically for persons with dementia or for populations that include persons with dementia. DCH and OSA administer funds for these programs.

The Michigan Dementia Coalition is a vital coordinating center for the broad spectrum of professionals and organizations in the field of dementia. It represents a diverse group and a unique collaboration of consumers, community groups, universities, and government units working to improve the quality of life of persons with dementia and their families in Michigan. Participants share information, identify opportunities to coordinate efforts, provide recommendations to the DCH, and seek meaningful ways to influence dementia awareness, policy, and service development in Michigan.

Annually, the DCH Public Health Administration funds the Michigan Public Health Institute (MPHI) dementia program to coordinate the Michigan Dementia Coalition, staff Coalition initiatives, and contract with the Alzheimer's Association Chapters for statewide toll-free help lines and other information, referral, and assistance services. MPHI contract agencies work together as the Dementia Information Network to maximize the effectiveness of their services. In 2008, network agencies support for family caregivers included[70]:

- Care Consultation - 4,014 participants
- Support Groups - 1,604 meetings with an average of 6 participants in each
- Helpline support - 8,454 contacts
- Educational Programs - 10,720 participants in 393 education programs for consumers

The Division of Program Development, Consultation and Contracts within the DCH Bureau of Community Mental Health Services administered the AoA Alzheimer's Disease Demonstration Grants to States projects 1992-2008. It also funds specialized pilot projects on staff and family dementia education through federal Community Mental Health Block Grants. The Division administers Alzheimer's caregiver education and respite programs with funding for Older Adult Mental Health Initiatives, conducted by local community mental health, the aging network, and the Alzheimer's Association. The Alzheimer's Caregiver Education Programs offer families and professional caregivers geographic access to community-based educational programs on dementing illnesses, behaviors, and related topics. About 5,000 people participate in caregiver education programs each year. The Alzheimer's respite services may include adult day care, group or in-home respite care, and ancillary support services, such as caregiver information, education, and crisis intervention. Approximately 600 families receive respite services each year. Dementia education is also provided through funding to Lansing Community College's Mental Health & Aging Project and Eastern Michigan University's Alzheimer's Education Program. The Older Adult Mental Health Initiatives funding has been eliminated in the Governor's proposed FY 2010 budget.

[70] Michigan Dementia Coalition, 2008, (www.dementiacoalition.org)

HCBS Programs

The majority of care given to persons with dementia is provided by unpaid family members in the family home. Michigan Medicaid provides services in the home for persons with dementia that meet financial and functional eligibility criteria. The Home Help program is available to assist with activities of daily living; however, supervision is not a covered service. Persons with dementia that meet the nursing facility level of care and financial eligibility criteria can access home care services, including supervision and respite, under the MI Choice waiver program, however this program does not provide for 24 hour care. Supports and services are available to persons age 60 and older with dementia and their caregivers under the Older Americans and Older Michiganians Acts.

The DCH Bureau of Mental Health and Substance Abuse Services provides medically necessary services to individuals with serious mental illness. In FY 2007,[71] the Community Mental Health Services Program provided service to over 8,900 consumers age 65 and over under the Medicare program and the Medicaid adult benefits waiver.

Various types of assisted living arrangements are available to serve persons with dementia including adult foster care, homes for the aged, or specialized memory care facilities. Most assisted living facilities serve people on a private pay basis. Licensed facilities provide room and board, supervision and personal care bundled into a daily rate. Unlicensed facilities operate as housing with services establishments, ensuring that supportive services are available for purchase from a pool of qualified providers. MI Choice waiver funds can be used to purchase services for individuals residing in unlicensed assisted living. Because Medicaid funding is generally unavailable in supervised assisted living settings, they are not considered an accessible option for receiving long-term care services. Persons unable to remain at home are forced to enter nursing facilities to receive the necessary level of care.

Non-HCBS Programs

Nursing facilities provide medical care, room and board, and specialized activities. Some facilities are considered special dementia or memory care facilities or have such units designated within the larger facility. Since almost half of nursing home residents have Alzheimer's or other dementia, and only 5 percent of nursing home beds are in Alzheimer's special care units, it is clear that the great majority of nursing home residents with Alzheimer's and other dementias are not in Alzheimer's special care units.[72]

[71] Michigan Department of Community Health's 2007 Statewide Summary & CMHSP Specific Report, Demographic Summary Data. http://www.michigan.gov/documents/DCH/Section_4042ai_Demographic_Summary_Data_239370_7.pdf

[72] Alzheimer's Association, Op. Cit., p. 54.

Demographic and Utilization Trends

The prevalence of individuals living with Alzheimer's disease is difficult to pinpoint. In Michigan, the Alzheimer's Association estimates the total number of individuals of all ages living with Alzheimer's disease to be approximately 180,000 cases.

Table 7-4 Estimated Prevalence of Individuals Age 65+ in Michigan with Alzheimer's disease 2010

	Projected Population[73]	Alzheimer's Estimate	
		Percent	Number[74]
Ages 65-74	699,458	1.2%	8,300
Ages 75-84	429,841	19.1%	82,000
Ages 85 and up	205,188	41.4%	85,000

Parkinson's disease is known to affect about 3% of the United States population. It is a disease that does not discriminate as to race or gender, attacking all equally.[75] Although accurate numbers are hard to come by, it is estimated that 50,000 Americans are diagnosed with Parkinson's each year. With the aging of the baby boomers, that number is expected to double in the coming decades. Fifteen percent (15%) of people with Parkinson's are diagnosed before the age of 65. This portion of the Parkinson's population has risen in the last few years to more than 2,500 people a year. It is estimated that nearly 40% of all cases go undiagnosed. Approximately 20% of people with Parkinson's disease develop dementia, usually after the age of 70.

Researchers compiling data for this report were unable to identify a source of data to estimate the prevalence of Huntington's disease in Michigan.

In Michigan there are an estimated 364,293 caregivers of persons with dementia providing nearly 315 million hours of unpaid care valued at over $3.49 billion annually.[76]

Businesses with employees who are caregivers of a person with dementia estimate their additional costs to be $36.5 billion nationally per year for lost productivity, missed work, and costs to replace workers who leave their jobs to meet demands of caregiving for a person with dementia.[77]

Summary

The challenges of reducing the burden of dementia are many. The stigma of dementia impedes early recognition, early assessment, early diagnosis and access to support services. The longer these are delayed, the more difficulties arise and the harder they are to address.

Supports for caregivers are lacking. Providing assistance and support to someone with declining memory and independence is typically a gradual process. The role of caregiver increases as the disease progresses. Many people who are providing assistance and support do not think of themselves as caregivers, may not recognize how much of a caregiving role they have assumed

[73] U.S. Census Bureau, Interim Population Projections for Five Year Age Groups and Selected Age Groups by Sex for States: July 2004-July 2030. http://www.census.gov/population/www/projections/projectionsagesex.html,
[74] Alzheimer's Association, Op. Cit., p. 21.
[75] The Michael Stern Parkinson's Research Foundation, www.parkinsoninfo.org, June 26, 2008.
[76] Alzheimer's Association, Op. Cit., p. 42.
[77] Op Cit, p. 48.

over time, and do not know about or how to access available supports. Research demonstrates that high-quality caregiver support services help keep people with dementia at home, help maintain their quality of life, help mediate the negative effects of caregiving, and save government and taxpayer dollars by delaying more expensive institutional care.

Significant effort is needed to improve long-term care for Michiganians with dementia. More education and dementia-specific training programs would be effective in these efforts. Public education is needed to increase general awareness of the early warning signs of dementia, the importance of early assessment, and the availability of resources to assist families and people with memory loss concerns or conditions. Mental health staff need training on effective ways to work with persons with dementia and to better assess secondary conditions such as depression or anxiety. Physicians and other professionals should be better trained in the early diagnosis of dementia and available treatments and resources. Law enforcement staff and first responders need training about typical behaviors of persons with dementia and appropriate interventions.

Persons in Correctional Facilities

Currently, the Michigan Department of Corrections (DOC) arranges for and administers medically necessary health care to approximately 48,118[78] prisoners annually at 40 correctional facilities, 10 camps, and two re-entry centers. DOC operates Duane Waters Health Center (DWH) in Jackson, which has 112 inpatient beds, and houses prisoners whose medical needs cannot be met at other correctional facilities within the state. DWH provides acute medical, outpatient, surgical, and long-term care services. It also administers a program outside the health center to care for 64 extended-care patients who do not require inpatient care at DWH, but whose needs cannot be met while in the general prison population.

Programs and Services

Most of the long-term care programs and services provided by DOC revolve around mental health. DOC provides prison-based mental health services to prisoners with mental or behavioral disorders housed in reception centers, general population, or segregation units. Psychological Services Units (PSUs), located at each prison, are operated by the DOC Bureau of Health Care Services. The DOC contracts with the DCH for the provision of services to the seriously mentally ill. These services are provided through the Corrections Mental Health Program (CMHP). The total number of prisoners on active treatment status in the CMHP for the period ending February 2009 is approximately 5,837[79] or 12.1% of the total population of prisoners.

Demographic and Utilization Trends

All adults and juveniles sentenced as adults convicted of offenses for which the statutory maximum is more than one year can be sentenced to the state's prison system. The targeted population for mental health services and long-term care services within the correctional setting is individuals that are severely and chronically mentally ill or are very ill and are in need of long-term care services. To meet eligibility for long-term care services within Michigan's prisons and camps, individuals must be unable to maintain activities of daily living without assistance or be severely disabled. A paroled individual must meet financial and functional eligibility requirements to receive ongoing services from Medicaid.

Because the current data focus is on mental health program and service utilization, it has been difficult to acquire data on the number of long term care consumers within the DOC system. However, the DOC and OLTCSS are actively working on developing a process to determine the number of Michigan prisoners that are medically fragile and potentially in need of long term supports upon parole.

DOC programs are supported by state general fund resources. There currently is no mechanism to readily break down total costs for health care services into the various components such as physician services or long-term care services. The FY 2008 projected expenditure for prisoner health care, including long-term care and mental health services, is over $258 million.

[78] Michigan Department of Corrections, Client Census Summary Report, 3/2009.
[79] Michigan Department of Corrections, Average Census: CMHP All Levels of Care Report, 3/2009.

Transition from Correctional Facilities

All former prisoners experience re-entry into the community whether released on parole or without supervision. The Michigan Prisoner Re-entry Initiative assists parolees to obtain necessary medical services in the community. Medicaid is the primary health care resource for persons paroled into the community.

OLTCSS and the DOC are exploring the potential for coordinating supports for parolees needing ongoing long term care services. The nursing facility transition protocols developed under Michigan's Money Follows the Person Initiative will serve as a model for the development of similar protocols to be used in planning transitions from correctional facilities.

Components Associated with Rebalancing

Participant Direction

DOC policy requires the active participation of parolees in placement planning and decision-making. DCH and DOC will explore how they can work together to ensure that parolees are engaged in the process and their choices supported.

Quality Management

As a result of concerns over the quality of health care being provided to prisoners by the MDOC, Governor Granholm ordered an independent comprehensive review of prisoner health care to assure that the current health care delivery system meets its commitments of providing quality, medically necessary health care that meets established program goals, in an efficient, cost-effective manner. In January 2007, a contract was awarded to the National Commission on Correctional Health Care (NCCHC) process to assess the DOC health care system. Their report[80] identified 56 recommendations for systemic change to improve the effectiveness and efficiencies of the DOC health care system. The DOC is in the process of redesigning key health services contracts, reorganizing its management structure, and improving contract management. It is intended that a culture of quality will be created by changing the business process, attaining greater compliance and accountability, and meeting performance measurements.

Summary

The DOC faces significant challenges in providing long-term care within the confines of the prison system. Issues around prison accessibility and availability of specialized services are systemic issues that need to be addressed by the DOC in designing programs to meet the long-term care needs of the incarcerated populations.

An additional set of barriers is present when developing community support plans for individuals being paroled who have ongoing long-term care needs. The most significant of the barriers are federal rules that prohibit sex offenders from living within a specific distance of schools, playgrounds, and child care facilities, which lead to difficulty in locating housing.

[80] "A Comprehensive Assessment of the Michigan Department of Corrections Health Care System" (January 2008) http://www.michigan.gov/documents/corrections/NCCHC_Response_222382_7.pdf

Members of Native American Tribes

With Michigan ranking in the top ten nationally among states with a significant American Indian population, long-term care programs and services to meet this group's special needs remain an integral part of the discussion in this state. Michigan has 12 federally-recognized tribes, four state historic tribes, and a large off-reservation urban population residing mainly in metropolitan Detroit. It has always been Michigan's goal to complement and/or build on federal initiatives impacting Native American individuals who need long-term care supports and services.

American Indians face similar issues in accessing long-term care supports and services as do their non-Native counterparts. The need for HCBS is extensive but is largely unmet. Although there is an array of providers and funding sources for HCBS, these are fragmented and often insufficient to meet the need. Family and friends are important providers of HCBS. The level of funding, service priority, appreciation of local need, limited access to decision makers, and excessive regulations are barriers to continuing or developing programs.

Programs and Services

There are many tribal and off-reservation health care programs and services across Michigan designed to address the unique needs of American Indians. Several have services designed specifically to address the long-term care needs of tribal members. A significant portion of the overall funding for long-term care programs and services is provided by the Department of Indian Health Services.

Funding for low income and senior housing is made available by HUD. Funding for programs such as child, family, and adult caseworkers, foster care, etc., come from other state and federal government agencies as well.

Older Americans Act and Older Michiganians Act services are available to American Indians through traditional aging network service providers. American Indians are also eligible to participate in any Medicaid programs for which they qualify functionally and financially.

Demographic and Utilization Trends

According to the 2000 Census, American Indians account for .3 percent of Michigan's population aged 60+. Seventeen (17%) percent of Michigan's elderly American Indian live below the poverty level. Among these, 37% are men and 63% are women, and 60% live alone. Of those aged 60+, 34 percent are 60-64 years of age, 39% are between 65 and 74, 24% are between 75 and 84, and 1% are over 85.

In 2007, services were delivered by aging network providers to 14% of the Michigan's American Indian population. The most often accessed services are caregiver supplemental services, homemaker, and personal care services.

Components Associated with Rebalancing

Building Infrastructure

An Aging Network and American Indian Forum has been established by the Office of Services to the Aging to provide a platform for building relationships between organizations and individuals that represent American Indians and the aging network. The forum is intended to enhance, promote, and strengthen services to elderly American Indians. Forum membership includes American Indian Tribes, off-reservation American Indian organizations, American Indian elders, area agencies on aging, local service providers, and state agencies. It meets on a quarterly basis to:

- Identify needs of the American Indian elders;
- Recognize the unique American Indian culture and provide services in a sensitive and respectful environment;
- Serve as a resource for the Michigan aging network;
- Provide a platform for exchange of information;
- Improve communication between state agencies and tribes, organizations, and individuals;
- Contribute as a resource for policy making decisions that may impact American Indian elders; and
- Provide strategies to reduce cultural barriers with access to service.

Participant Direction

Although there is no formal person-centered plan/self-determination process in place in most tribal long-term care programs and services, several tribes have programs and services in place that encourage and allow choice within their long-term care options.

Summary

As is the case for non-native Michiganians, there is a shortage of HCBS services and lack of funding for prevention programs and services. Facility-based long-term care is generally available only through off-reservation providers which is often an unattractive option for those requiring institutional services.

Issues remain around education, relationships/trust, cultural competence, outreach and access, and funding. OSA will continue to work with the Aging Network and American Indian Elder Forum to strategize ways to improve access and service delivery to elderly American Indians.

SECTION 8 OTHER ISSUES IMPACTING LONG-TERM CARE

Issue One: Long-Term Care Workforce

An adequate supply of skilled and knowledgeable employees is necessary for the successful operation of five-thousand plus licensed and certified providers and to the growing number of self-directed consumers. The Michigan LTC Task Force recognized the overall importance of the LTC workforce with recommendations to address recruitment, training, compensation, and value of this element of the system's infrastructure. The Task Force recommendations also called for improved workforce data collection and analysis.

Some important data about the LTC workforce is available from several state and federal departments and from stakeholder organizations (e.g., provider associations, organized labor) which have conducted their own surveys or analyzed public databases. Also, some available workforce databases are not focused solely on the long-term care supports and services sector but include employees from other health care settings. At present, the state has not identified a set of workforce data to be collected and analyzed.

A national workforce resource center and discussion has constructed a LTC workforce minimum database for state use. In April of 2008, the national Direct Services Workforce (DSW) Resource Center, funded by the Centers for Medicare and Medicaid services, responded to the requests from a number of states for guidance on basic LTC workforce data and measurements. The DSW Resource Center produced a paper[81] outlining for states the workforce data collection measurements to support long-term care reform efforts. The workforce minimum data set (WMDS) focuses on workforce volume, stability, and compensation and is designed to aide states in:

- Identifying and setting planning priorities.
- Formulating policy.
- Promoting system-wide coordination and planning while using comparable data.
- Monitoring progress on workforce initiatives.
- Comparing progress across states or with overall national performance.

This section of the Michigan profile will report the state's LTC workforce information using this workforce minimum data set developed by the DSW Resource Center.

LTC Workforce Volume - Number of Full-Time and Part-Time Workers

The DSW Resource Center paper recommends states collect the number of full-time and part-time employees. Unfortunately, this basic data about the size and make-up of the LTC workforce is not available across Michigan's entire array of long-term care supports and services programs or settings.

At present, accurate information about the sheer number and types of employees/jobs is only available for nursing homes and the Home Help program. From the Medicaid nursing home cost reports for 2007, the DCH Medical Services Administration reports the state's Medicaid funded homes had a staff complement of:

[81] "State Long-Term Care Reform: The Need for Monitoring the Direct Service Workforce and Recommendations for Data Collection," by Direct Service Workforce Resource Center, April 2008, www.dswresourcecenter.org.

Table 8-1 Staff Complement, Michigan Medicaid-Funded Nursing Facilities, 2007

Staff Type	FTEs
Registered Nurse	3,655
Licensed Practical Nurse	7,648
Nursing Aide	24,584
Director/Assistant Director of Nursing	980
Social Work staff	1,203

During fiscal year 2008, the DHS reports that a total of 58,000 individuals were employed through the Home Help personal care services program, with a monthly average of 43,729 individuals employed throughout the entire fiscal year.[82]

Other public databases and surveys conducted for provider associations and unions are important resources for data elements to provide a more complete picture of the size and make-up of the LTC workforce. For example, in the summer of 2008 the Michigan Assisted Living Association (MALA) conducted a Wage and Benefit survey of the state's mental health providers who deliver residential services with funding from local Community Mental Health boards.[83] While not all residential mental health providers responded to the survey, a substantial workforce was reported:

Table 8-2 Staff Complement, Michigan Mental Health Residential Care Providers

Staff Type	FTEs
Frontline direct care	6,529
Frontline supervisors, house managers	696
All other (usually administrative)	445

Data collected by the U.S. Department of Labor and Michigan Department of Energy, Labor and Economic Growth (DELEG) can provide estimated numbers of people working in all health care and personal support occupations and information about some provider groups within the entire health care sector. This workforce data does not include "independent contractors" or people working for self-directed consumers using Home Help, MI Choice, and other Michigan programs. It also does not provide detailed information regarding employers.

Table 8-3 Michigan Health Care Employees by Occupation, May 2007[84]

Occupation	Number Employed	Average Hourly Wage
Registered Nurse	84,480	$29.34
Occupational Therapist	3,740	$29.54
Physical Therapist	5,890	$34.00
Licensed Practical Nurse	18,650	$19.42
Home Health Aide	32,210	$9.76
Nursing Aide	48,860	$12.15
Personal Care Aide	12,400	$10.02
Medical and Public Health Social Worker	4,380	$22.54
Speech-Language Pathologists	3,400	$33.62

[82] MDCH Data Warehouse
[83] MALA Mental Health Provider 2008 Wage and Benefit Survey, conducted in fall of 2008. Results are to be released in March, 2009. Out of 297 surveys mailed, 55 useable responses were received. The responding sample is geographically representative of this sub-set of licensed Adult Foster Care homes.
[84] U.S. Bureau of Labor Statistics, www.bls.gov

As demonstrated below, Michigan-specific information created by the Labor Market Information section of DELEG provides the historic estimates of employees within an industry and projects job growth through 2016.

Table 8-4 Historic and Projected Michigan Employment in LTC, Healthcare, and All Employment Sectors[85]

Industry Sector	2006 All Employees	2016 All Employees	Projected Increase	Percent of Change
Home Health Services	26,855	35,800	8,945	33.3%
Nursing and Residential Services (includes "assisted living" facilities)	91,600	106,697	15,097	16.5%
TOTAL for Long-Term Care	118,455	142,497	24,042	20.3%
TOTAL for all Healthcare	475,800	549,525	73,725	15.5%
TOTAL for all Employment Sectors	4,327,170	4,622,580	295,410	6.8%

These projections represent all employees - nursing, maintenance, billing, administration, and sales - within a sector. They show the dramatic increases expected in the number of all positions to be created in the home care sector (33.3%) as compared to the overall economy (6.8%). Also, the projected job creation in LTC (20.3%) is substantially higher than the entire healthcare sector (15.5%). This state database does not parse out the size of occupational growth (RNs, LPNs, home health aide, personal care aide, etc.) within each industry, program (MI Choice, hospice, etc.), or setting (nursing homes, adult foster care homes, etc.).

Occupation projections by DELEG show "home health aide" is the second-fastest growing occupation of all jobs in the state, increasing by a third, and will add nearly 11,000 positions by 2016. Additionally, both the "home health aide" occupation and "nursing aide, orderly, and attendants" occupation are in the top ten largest growing occupations and will add more than 18,000 positions to Michigan's service sector by 2016.[86]

Workforce Stability - Turnover Rate and Vacancy Rate

Turnover rate refers to the calculation of both voluntary and involuntary separations from employment over a twelve-month period. For the consumer of long-term care supports and services, the loss of a capable caregiver may translate into the loss of a known caregiver who understands and respects the individual's preferences and needs. Research indicates each direct care worker separation results in $2,500 in direct costs and another $1,000 in indirect costs.[87]

Vacancy rate refers to the number of unfilled positions on a particular date. For a consumer, a vacant position can mean undelivered services, rushed services, or poorly delivered services by a caregiver not familiar with the individual's preferences and needs.

At present, Michigan does not routinely collect or analyze turnover or vacancy rates in any setting or program. However, some turnover data has been collected in the past by DHS and through provider association surveys of their members.

[85] Michigan Labor Market Information, www.milmi.org.
[86] State projections for both occupations and industry sectors can be found at http://www.milmi.org/?PAGEID=67&SUBID=177.
[87] "The Cost of Frontline Turnover in Long Term Care," by Dorie Seavey, Ph.D., October 2004, a publication of the Better Jobs Better Care initiative funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies.

In July of 2000, DHS conducted a random telephone survey of Home Help recipients.[88] For the 12% of survey respondents who were not currently receiving services, about one-fourth of them were experiencing turnover and vacancy issues ("provider quit," "fired provider," "did not like/get along with provider," and "cannot find a new provider").

In the nursing home arena, both the Health Care Association of Michigan (HCAM) and its national organization, the American Health Care Association (AHCA), have surveyed nursing facilities and calculated estimated turnover rates from the responses. The most recent report issued by HCAM[89] from 2002 reports turnover rates of 48.5% for CNAs, 28.4% for LPNs, and 25.7% for RNs. AHCA's national survey[90] of all nursing facilities in the nation estimated both turnover and vacancy rates along five nursing home job titles across the country and in all fifty states. The estimated Michigan turnover and vacancy rates are consistent with national trends in nursing facilities.

Table 8-5 Vacancy and Turnover Rates in Michigan Nursing Homes[91]

Position	Vacancy Rate on 6/30/2007	Turnover Rate
Director of Nursing	1.9%	41.9%
RN with Administrative Duties	4.7%	20.9%
Staff RN	12.3%	49.3%
LPN	10.3%	58.7%
CNA	7.6%	54.4%

Using the Medicaid cost report data outlined above, it is possible to estimate the number of vacant positions in Michigan. There were an estimated 580 vacant LPN positions and 1,636 vacant CNA positions on June 30, 2007.

Additionally, the MALA wage and benefit survey referenced on page 64 collected both turnover and vacancy data. The survey of 55 provider organizations reported an average turnover rate of 49% among direct care workers. This set of residential providers had 347 vacancies among direct care workers and 23 vacancies among their compliment of frontline supervisors on the day the survey was completed.[92]

At this time, turnover or vacancy rate data is not available for Michigan's adult foster care homes, homes for the aged, the MI Choice waiver or any other waiver provider, certified home health agencies, Home Help, hospice, PACE programs or other long-term care supports or services.

[88] "Customer Satisfaction Survey of the Home Help Services Program," Prepared by The Survey Center, Office of Quality Control and Special Projects, Budget, Analysis and Financial Management, Family Independence Agency.
[89] "2002 Wage and Personnel Survey" prepared by HCAM, May 2003.
[90] "Report of Findings 2007 American Health Care Association Survey Nursing Staff Vacancy and Turnover in Nursing Facilities," AHCA, Department of Research, July 21, 2008.
[91] AHCA 2007 Survey of Nursing Facilities, www.ahcancal.org
[92] MALA Mental Health Provider 2008 Wage & Benefit Survey.

Workforce Compensation - Average Hourly Wage, Health Insurance, Paid Time Off

The recommended three elements of compensation - wages, health insurance and paid time off - form for most working adults the critical elements to accepting a particular job with a specific employer or provider and being able to support oneself and one's family. At present, Michigan does not collect or analyze any of the three recommended compensation elements for any of the supports and services offered except for the Home Help program.

While Home Help provider wage rates range between $7.50 to $10.50/hour from county to county, the vast majority of providers are paid at the lower end of the wage scale. Neither health insurance nor paid time off is available to Home Help providers. In a telephone survey of a randomly selected sample of Home Help providers, 29% were uninsured and 33% relied on either Medicaid and/or Medicare for health care coverage.[93]

The most recent wage data available for LTC occupations in the state is in Table 8-1 above on page 65. While illustrative of the range of wage levels among the various job titles, caution is needed when ascribing the salary rates to people working in any LTC setting or program. This Michigan data from May of 2007 includes all work settings - hospitals, schools, assisted living, and home care agencies. The wage data also does not include Home Help providers since they are "self-employed" or "independent contractors."

Provider association surveys give additional insights into wage rates and paid time off. The 2008 MALA survey of mental health providers reports the average wage for direct-care workers is $8.60 per hour and is $13.27 for frontline supervisors or house managers. Paid sick time was offered by 65% of employers participating in the MALA survey; 92% of these providers offered paid vacations. Also, 91% of the employers offer health insurance to employees who work an average of 35 hours per week or more.

The 2002 HCAM survey of nursing homes indicates almost all nursing homes offered health insurance to their employees and paid time off to full-time employees. For part-time employees (usually anyone working less than 32 hours a week), access to health insurance was rarely offered and paid leave time was more restricted.

Insights on the abilities of LTC providers to offer health insurance were realized in a 2006 survey of all nursing homes, adult foster care homes, homes for the aged, and certified home health agencies. The survey was conducted by the Paraprofessional Healthcare Institute (PHI) with the active assistance of HCAM, MAHSA, MHHA, MCAL, and MALA.[94] Most of the findings were consistent with the findings of a DCH-sponsored randomized sample survey of all Michigan employers conducted about the same time.[95] The results of the PHI survey of LTC providers are as follows:

- Large employers with more than 100 employees and/or annual revenue of more than $500,000, generally offer health insurance to their employees.
- Much of the offered insurance is unaffordable to low-wage workers such as certified nursing assistants, personal care aides, and home health aides.

[93] "No Care for Caregivers: Findings from a Survey of Michigan's Home Help Workforce," Report to the MI Quality Home Care Coalition, December 2006, from PHI, http://www.hchcw.org/uploads/pdfs/hchcw_misurvey.pdf.
[94] "Beyond Reach? Michigan Long-Term Care Employers are Struggling to Provide Health Coverage for Employees," PHI's Health Care for Health Care Workers. www.coverageiscritical.org
[95] "State Planning Grant for the Uninsured Michigan Employer Health Insurance Survey." Full project description and documents at http://www.michigan.gov/mdch/0,1607,7-132-2943_37434---,00.html

- Small employers (such as family and small adult foster care homes) with fewer than 10 employees and revenues below $500,000 rarely offer health insurance.

Through analysis of publicly available databases, additional information about wages, income, health insurance, and other benefits has been identified. Using the federal "Current Population Survey, March Supplement of pooled data from 2005 to 2007, a clearer picture of the annual incomes and public assistance used by the state's direct-care workforce is reported by PHI,[96] including:

- Average annual earnings for Michigan direct-care workers are less than the amount necessary to meet basic expenses without relying on government or nonprofit assistance.
- Only 50% of the state's direct-care workers work full-time. This contributes to low and unpredictable income for their families and ineligibility for employer-based health insurance.
- Approximately 25% of the state's direct-care workforce is uninsured; this rate is twice as high as it is for the general population.
- One-third of the direct-care workforce live in households that rely on some kind of public benefits such as Medicaid or food stamps.

Summary

At present, Michigan's health care, reimbursement and labor systems do not collect, analyze or use basic data about the composition, size, stability or compensation of the state's long-term care workforce.

[96] "State Facts: Michigan's Direct-Care Workforce," published by PHI Michigan. http://www.directcareclearinghouse.org/download/PHI-StateFacts-MI.pdf.

Issue Two: Housing

Adequate housing is a crucial infrastructure support to many Michigan residents who need or utilize long-term care supports and services. Anyone who suddenly acquires a significant disability and needs long-term care supports and services may also suddenly need accessible and affordable housing. Access to affordable, accessible housing is consistently identified as a barrier to individuals in nursing facilities who would prefer to live in the community.[97] Those needing long-term care supports, and services who also need affordable and accessible housing find themselves competing with many others to acquire low-income housing.

Michigan has 132 Public Housing Agencies (PHAs) managing public housing units and programs across the state.[98] All of these PHAs receive federal housing dollars directly from HUD and are locally based.

The Michigan State Housing Development Authority (MSHDA) is a PHA and a state government entity; however, as a state government entity, it has no authority over other local PHAs. MSHDA manages public housing units across Michigan in both urban and rural communities. Therefore, it is sometimes present in communities with other PHAs.

MSHDA housing programs which may be available to people with disabilities and elderly who also need long-term care supports and services, along with others who have housing needs, include the following:

- **Property Improvement Loans**
  MSHDA's Property Improvement Program (PIP) was established to provide decent, sound, safe, and sanitary housing for eligible residents of Michigan. Almost any type of permanent general property improvement can be made. PIP low-interest loans can be a resource for people with long-term care needs who need environmental modifications to improve accessibility.

- **Housing Choice Voucher Program**
  This federal program provides rent subsidies for people with very low incomes. Individuals may take their subsidy to private homes and apartment buildings. HUD allows local PHAs to project-base up to 20% of their allocation to meet the needs of supportive housing tenants. Of the 24,000 housing choice vouchers in Michigan, over 9,000 households include a person 55 years or older.

- **Affordable Assisted Living Pilot Program**
  The Affordable Assisted Living Pilot Program was developed in 2005 to address the lack of affordable housing for the elderly who are forced to remain in, or enter nursing facilities because they cannot afford the assisted living options available in the community. This project combines MSHDA Housing Choice Vouchers with the MI Choice waiver program in order to provide eligible clients with a choice of affordable assisted living as an alternative to nursing home care. There are five demonstration projects, one of which will begin serving consumers in the spring of 2009.

[97] Michigan Nursing Facility Transition reports 2000 to 2008. Michigan Department of Community Health.
[98] U.S. Department of Housing and Urban Development. Homes and Communities. Michigan PHA Contact Information.

- **Supportive Housing**
  Supportive housing is a combination of affordable housing with services that helps people to live more stable and productive lives. There are various models of supportive housing. Generally, a supportive housing unit is defined by the following elements:

  - The unit is available to, and intended for a person or family whose head of household is homeless or at risk of homelessness, and has multiple barriers to employment and housing stability, which might include mental illness, chemical dependency, and/or other disabling or chronic health conditions.
  - The tenant household has a lease (or similar form of occupancy agreement) with no limits on length of tenancy, as long as the terms and conditions of the lease or agreement are met.
  - The unit's operations are managed through an effective partnership among representatives of the project owner and/or sponsor, the property management agent, the supportive services providers, the relevant public agencies, and the tenants.
  - All members of the tenant household have easy, facilitated access to a flexible and comprehensive array of supportive services designed to assist the tenants to achieve and sustain housing stability.
  - Service providers proactively seek to engage tenants in on-site and community-based supportive services, but participation in such supportive services is not a condition of ongoing tenancy.
  - Service and property management strategies include effective, coordinated approaches for addressing issues resulting from substance abuse, relapses, and mental health crises, with a focus on fostering housing stability.

- **The Michigan Housing Locator**[99]
  The Michigan Housing Locator is a website devoted exclusively to putting residents in touch with property owners who specialize in affordable housing. Industry leaders - including MSHDA, Michigan Housing Council (MHC), Property Managers Association of Michigan, and RentLinx - teamed up to ensure the success of the locator. Access to the Michigan Housing Locator website is available at no cost to both landlords and the public, twenty-four hours a day, seven days a week. The Michigan Housing Locator provides a full picture of properties available and is a source for Section 8 Voucher holders to find out which landlords will accept the vouchers.

- **Low-Income Housing Tax Credit (LIHTC)**
  This program, created by Congress as a part of the Tax Reform Act of 1986, as amended, is designed to assist in the creation and preservation of affordable rental housing for low-income households. This program provides a dollar-for-dollar reduction in federal tax liability for owners of and investors in qualified rental housing over a ten-year period.

MSHDA's programs are targeted to people with varying income levels. Many of the programs have additional target groups for designated housing set-aside, including persons with disabilities and the low-income elderly, and measure income eligibility in terms of the percentage of Average Median Income (AMI) into which a household falls. MSHDA programs targeting seniors are available to those 55 years and older.

[99] www.michiganhousinglocator.com

A variety of funding is used to support MSHDA's housing programs. Their lending program for multifamily housing is funded primarily from bond proceeds, although federal Investment Partnership (HOME) funds are often used as well. Also, federal tax credits administered by MSHDA are used to raise equity for investment in these developments. Rental subsidies that allow renters to pay only 30% of their incomes for rent are funded with federal money. Federal Community Development Block Grant (CDBG) funds are used to assist smaller communities and counties for home upgrades and various other housing activities. Most supportive housing projects are created by non-profit housing organizations that utilize a combination of sources including: Low-Income Housing Tax Credit, HOME, Federal Home Loan Bank, foundation, and bond financing. In Fiscal Year 2008 a new state appropriation of $2.2 million in state general funds was created for MSHDA to use for various housing projects.

Summary

Challenges faced by MSHDA in providing affordable housing to seniors and people with disabilities who also have long-term care needs include:

- Insufficient availability of housing programs, including vouchers and subsided housing units to serve low-income households;
- PHAs have great latitude in determining which target group has housing priority which results in a wide variance in who actually gets housing from one PHA to the next;
- The complexity of blending the many incongruous types of regulations and funding sources for people needing long-term care services and supports within MSHDA properties;
- The lagging housing market, which makes it difficult for seniors wishing to downsize to first sell their home;
- Michigan Barrier-Free laws differ from the section 504 laws, which, at times causes conflicts;
- Landlords do not enforce laws pertaining to occupancy of accessible units;
- MSHDA does not have a quantifiable estimate of unmet needs for specific programs, however, with the aging of the baby boomers, it is clear there will be an accelerated need for housing targeted to low-income seniors, affordable housing with services, assistance with home repairs, and other housing-related assistance;
- MSHDA's five-year plan is to support congregate housing, however, advocates continue to ask for more inclusive housing options; and
    - Landlords' waitlists should be reviewed to determine whether there are an unusual number of persons with disabilities on the list for any given unit.

There clearly remains significant work to be done to improve access to affordable housing for elderly Michiganians and persons with disabilities.

APPENDICES

APPENDIX A - RESOURCES/SUPPORTS FOR LONG-TERM CARE INDIVIDUALS

While this profile focuses on long term supports and services, there are many other supports that are vital to older adults and people living in the community. This appendix describes those common support programs and provides recent utilization data where available.

Medical Programs

People with disabilities and older adults can have significant health needs that affect community living. Medicare and Medicaid are important sources for medical care for Michigan's elderly and persons with disabilities.

Medicare

Medicare is a federal health insurance program available for almost all people age 65 or older, people under 65 with certain disabilities, and people of all ages with End Stage Renal Disease. Medicare has several parts. Part A (hospital insurance) is funded by payroll taxes and helps pay for inpatient hospital care, limited skilled nursing care, hospice care, and some home health care. Part B (medical insurance) helps pay for doctors' services, outpatient hospital care, and other medical services. It is financed by a monthly premium paid by the participant. Services are available on a fee-for-service basis (Parts A and B) or through managed care organizations (Part C – Medicare Advantage). Just over 1.5 million Michiganians received Medicare in July 2006.[100]

Medicare Part D helps pay for prescription drugs, insulin, some injections and diabetic supplies used to inject insulin. It is available either through stand-alone prescription drug plans or through all-inclusive Medicare Advantage plans that cover drugs and all other Medicare services. Part D is financed by a monthly premium paid by the participant. A Medicare retiree drug subsidy is available for people with low income and resources. As of February 1, 2009, 842,014 Michiganians are enrolled in either a stand-alone or Medicare Advantage plan. An additional 349,843 are supported with the Low-Income Subsidy.

Medicare Cost Sharing Programs

The Medicare Cost Sharing (MCS) or Medicare Savings programs provide help with Medicare expenses for people who are age 65 or older, blind, or disabled. There is no limit on resources, such as cash, bank accounts, stocks, or bonds. Applicants for all programs must be eligible for Medicare Part A hospital insurance. The income limits, special eligibility requirements, and benefits for each program are listed below.

- Qualified Medicare Beneficiary (QMB) - The monthly income limits for this program are determined by the federal government. Benefits are payment of the Part A and Part B Medicare premiums, deductibles, and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLMB) - The individual must be receiving or entitled to receive Medicare Part B. Monthly income is determined by the federal government. The SLMB benefit is payment of the Medicare Part B premium.
- Qualified Individual (QI) - Monthly income is determined by the federal government. The QI benefit is payment of the Medicare Part B premium.

[100] U.S. Centers for Medicare and Medicaid Services "Medicare Enrollment – All Beneficiaries: as of July 2006."

Medical Assistance (Medicaid, MA)[101]

Medicaid provides medical assistance to individuals and families who meet the financial and non-financial eligibility factors. The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. The DCH administers Medicaid and the Adult Medical Program. The DHS implements the program through central office policy analysts and local office specialists. Medicaid is now the single largest health insurance program in the United States (recently bypassing Medicare).

Most Michigan Medicaid enrollees receive medical care through managed care organizations however those with dual Medicare and Medicaid eligibility are excluded from participating in the managed care plans. Medicare is the primary payer for dual eligible individuals and is used for medical needs such as hospital and physician services. Medicaid covers co-payments, deductibles, and services not covered by Medicare.

Demographics
As of October, 2008 there were 1,983,655 Medicaid recipients; 50,410 enrolled as Adult Medicaid Program (active H cases). During FY 2008 there were an average 44,304 monthly applications filed, with recipients active in 30 Medicaid categories.

Sources of Financing
Federal Social Security Act, Title XIX
State funds
County funds
Federal demonstration funds

Program Effectiveness
As of October 31, 2008 Medicaid Beneficiaries by Age:

Age 0-19	964,051
Age 20-64	890,758
Age 65 plus	128,846
Total	1,983,655

Diagnosis Specific Programs

The State operates several programs that target services to people with specific diagnoses that may cause disability (shown below). Some programs directly pay for individuals' services when private and public insurance is not available and the family meets income guidelines. Other programs fund prevention activities dedicated to a specific cause or disease.

- Adolescent Health
- Arthritis
- Asthma
- Breast & Cervical Cancer Screening
- Childhood Lead Poisoning Prevention
- Comprehensive Cancer Control
- Diabetes Prevention
- Early Hearing Detection & Intervention
- Early On (Part C of IDEA)

[101] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs

- Fetal Alcohol Spectrum Disorders
- Fetal Infant Mortality Review (FIMR)
- Hearing Screening
- HIV/AIDS
- Infant Mortality Initiative
- Maternal Infant Health Program
- Maternal Mortality Surveillance
- Oral Health
- Pregnancy Risk Assessment Monitoring & Surveillance
- Prenatal Smoking Cessation
- Sudden Infant Death Syndrome & Other Infant Death Services
- Tobacco Cessation (Telephone Quitline)
- Tobacco Reduction
- Vision Screening
- WISEWOMAN Program
- Children's Trust Fund
- State Medical Program
- Children's Ombudsman
- Elderly Mobility

Medicare/Medicaid Assistance Program (MMAP)[102]

MMAP empowers beneficiaries and their families to make informed health care decisions by providing objective health benefits information. MMAP's mission is to provide education, advocacy, and consumer protection assistance services to Michigan's older adults and individuals with disabilities, and those who serve them.

MMAP is a federally funded program that is accessible statewide via a toll-free, geo-routed helpline. There are 58 MMAP locations with over 590 trained MMAP counselors and coordinators that provide information and counseling on a variety of topics, including Medicare and Medicaid eligibility, medical coverage, enrollments, claims, post-enrollment issues, grievances, appeals, fraud, abuse, and identity theft related to Medicare, Medicaid, managed care, Medigap and long-term care insurance.

MMAP is the recognized leader in Michigan in providing high quality and accessible health benefit information and counseling services that are supported by a statewide network of volunteer and paid professionals. During 2008, MMAP counselors helped beneficiaries save over $16 million in out-of-pocket expenses, and 19,446 people received individual counseling. MMAP's toll-free helpline received 40,000 calls, and its outreach and enrollment events reached 84,469 individuals.

MiRx (My Prescription)

The MiRx (My Prescription) Card is a prescription drug discount program for Michigan residents who do not have any prescription drug coverage. The MiRx Card program is free; there are no costs for either the card or enrollment. MiRx card holders present their card at the pharmacy when filling the prescription. The pharmacist charges a published, discounted price. The MiRX discount is good for any prescription. Over-the-counter drugs are not covered.

[102] Office of Services to the Aging, 2008 Annual Report

To be eligible to participate in the MiRx Card program, each family member, or member of a household, must be enrolled in the program. There is no age limit to participate in the MiRx Card program.

Applicants must be a resident of Michigan, have no other prescription drug coverage, and have an income at or below the state's median income level.

Size of Family Unit	MI Median Income
1	$31,200
2	$42,000
3	$52,800
4	$63,600

Size of Family Unit	MI Median Income
6	$74,400
7	$85,200
8	$96,000
9	$106,800

Nutrition Programs

Food Assistance Program (FAP)

The goal of the Food Assistance Program (FAP) is to raise the food purchasing power of low-income persons. Limited food purchasing power contributes to hunger and malnutrition. The FAP is one of the federal safety net programs. Benefits are 100% federally funded and administrative costs are shared equally between the state and the federal government.

FAP benefits can be used to buy eligible food at any Food and Nutrition Service authorized retail food store or approved meal provider. Eligible items include any food or beverage product intended for human consumption except alcoholic beverages, tobacco, and food prepared for immediate consumption.

As of July 2001, Michigan's food assistance and cash assistance benefits began being provided through electronic benefits transfer (EBT). EBT for food assistance replaced paper coupons with a debit card.

Sources of Financing

- 100% federal funding for Food Assistance benefits through the U.S. Department of Agriculture Food and Nutrition Service (USDA-FNS)
- 50% USDA-FNS funding for associated administrative costs less any FA administrative expense amount determined to have been included in the TANF Block Grant
- State funds
- Public assistance recoupment

Program Effectiveness

In FY 2008, the average number of households receiving FAP monthly was 594,778, providing supplemental food benefits to an annual average of 1,262,952 people. Both figures were all-time high annual records. In October 2008, record monthly program levels were again set with 625,744 households and 1,303,093 recipients. Current trends and Michigan's continued economic challenges are expected to move FAP household and recipient levels higher through Fiscal Year 2010.

Nutrition Services for the Elderly

Adequate nutrition is critical to health, functioning, and the quality of life. Nutrition services provide nutritious meals in community settings and to homebound older adults. They are an important component of home and community-based services for older adults. In addition to a hot meal, nutrition services combat social isolation, provide nutrition education, and offer an important link to other needed in-home and community-based services. At the end of 2007 there were 643 congregate meal sites operating across Michigan.

Sources of Financing

- Older Americans Act Title III-C and Title III-E
- State GF/GP funds
- Local matching funds
- Program income

Program Effectiveness

Approximately $50.7 million was spent to provide nutrition services for the elderly in 2007 to provide 49,717 individuals with 7,900,712 home delivered meals and 62,730 individuals with 2,922,179 meals in a congregate setting. Additionally, 81,979 home delivered meals were provided to caregivers as a form of respite care.[103]

Senior Project FRESH[104]

Senior Project FRESH is Michigan's Senior Farmers Market Nutrition Program sponsored by the US Department of Agriculture, Food and Nutrition Services. The program was developed to help support local farmers markets and roadside stands. In Michigan, it benefits low-income older adults, as well as farmers. The program provides individuals age 60 and older, who are at 185 percent of poverty or less, with coupons redeemable for Michigan-grown, unprocessed produce at farmers markets and roadside stands. Program participants also receive nutrition education classes, one-on-one counseling, and cooking demonstrations.

In 2008, 64 counties participated in the program and distributed over 180,000 coupons to eligible persons. Funding was available for the lead agencies and markets to provide for transportation, nutrition education, and cooking demonstrations.

Income Support Programs

Supplemental Security Income (SSI)[105]

Supplemental Security Income (SSI) is a federally administered income maintenance program for the aged, blind and disabled. Six categories of living arrangements are recognized: Independent Living, Household of Another, Domiciliary Care (Supervisory), Personal Care, Home for the Aged and Medicaid Facility, i.e., nursing home. Payment amounts vary by living arrangements. Federal payments are supplemented with state funds. The majority of these state funds are paid to persons in independent living arrangements. Additionally, Medicaid payments for personal care services are provided for persons who need these services in adult foster care categories.

[103] NAPIS, Michigan 2007
[104] NAPIS, Michigan, 2007
[105] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs

The Social Security Administration (SSA) charges the state a fee, per transaction, for administering state funds. To minimize these fees the state administers the state funds paid to those persons in Independent Living and Household of Another living arrangements with the state SSI Payment program. This group constitutes approximately 93% of the total number of SSI recipients receiving state funds. The SSA administers state funds to mandatory SSI individuals in all living arrangements and those in Domiciliary (Supervisory) Care, Personal Care, Home for the Aged and Medicaid Facility living arrangements.

Sources of Financing
SSI benefits are 100% federally-funded. State supplementation of the federal SSI benefit is 100% state-funded.

Program Effectiveness
To enhance the financial stability of families, Michigan will continue to pursue benefits for disabled and financially needy adults and children through SSI.

Supplemental Security Income

Fiscal Year	*Total Recipients*
2005	219,115
2006	221,743
2007	225,347
2008	227,917

Disability Determination Service (DDS)[106]

The Michigan Disability Determination Service (DDS) determines initial and continuing eligibility for disability benefits for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicaid Assistance (MA), State Disability Assistance (SDA), and the Office of Retirement Services (ORS) disability retirement program. SSDI, MA and SDA programs have the same medical/vocational eligibility criteria.

Social Security Disability Insurance (SSDI) benefits are paid to eligible individuals who cannot work for at least a year because of a serious physical or mental disability. To qualify, an applicant must have worked in a job where both the individual and the employer paid Social Security taxes for an adequate number of fiscal quarters before the onset of the disability. Disability benefits are paid to insured individuals who become unable to work because of illness or injury that is expected to last at least 12 continuous months or is expected to result in death. The definition of disability is one that only the severely disabled can meet. There are no income or asset requirements for SSDI.

Supplemental Security Income (SSI) is a needs-based program that provides coverage for people whose income and assets are below a certain level. There is no requirement for prior employment. SSI disability criteria are the same as the SSDI criteria described above. SSI recipients receive Medicaid.

Eligibility Factors
The Social Security law contains a listing of impairments and a description of the evidence needed to evaluate the disability. Benefits are allowed when the applicant's impairments meet or equal the listed medical criteria. The Social Security law also contains vocational criteria which are considered in cases where the impairment fails to meet or equal the medical criteria,

[106] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs

but the physical or mental capacity to perform basic work-related activities is limited. The remaining or equal capacity to perform work is assessed along with age, education and past work experiences to determine eligibility for disability benefits.

Sources of Financing
SSDI benefits are 100% federally-funded.

State Disability Assistance (SDA) Program[107]

The State Disability Assistance (SDA) program provides financial assistance to Michigan's disabled low-income adults to meet basic personal and shelter needs. SDA is a cash assistance program for disabled adults, caretakers of disabled individuals, and persons age 65 or older. SDA recipients have little or no money to pay for living expenses such as rent, heat, utilities, clothing, food or personal care items and SDA is intended to meet these basic needs. The monthly maximum benefit for FY 2009 is $269 ($423 for a married couple). In addition, SDA recipients with no other income are eligible to receive $176 per month in food assistance. SDA cases can be composed of a single person or spouses who live together.

Eligibility Factors
To be eligible for SDA, applicants must meet income and asset requirements. Most types of earned and unearned income are counted when determining eligibility. A full-time minimum wage job exceeds SDA income eligibility standards. The asset limit for SDA is $3,000. However, most SDA recipients do not have assets or income.

A person must also meet disability criteria, be caring for a disabled person, or over the age of 65. An individual meets disability criteria for SDA if the individual:

- is receiving Social Security Income (SSI), Social Security benefits based on their own disability, or Medicaid due to a disability;
- meets the federal Social Security Administration (SSA) disability standards with the exception of duration;
- is age 65 or older, and has applied for benefits with the SSA;
- is receiving services from Michigan Rehabilitation Services;
- is receiving special education services through a local intermediate school district and is under the age of 26;
- is caring for a disabled person when assistance is medically necessary for at least 90 days and the disabled individual and the caretaker live together;
- is residing in an adult foster care home, home for the aged, a substance abuse treatment center (SATC), or a county infirmary;
- is receiving post-residential substance abuse services. Individuals are SDA eligible for 30 days following discharge from the SATC; or
- has an AIDS diagnosis.

Sources of Financing
State GF/GP funds
SSI recoveries

[107] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs

Program Effectiveness

The SDA average monthly caseload was 10,364 persons in 2008; it is projected to decrease through FY 2010. The average monthly grant in 2008 was $273. Most recipients are single adults between 18 and 65 years of age.

State Disability Assistance

Fiscal Year	*Average Monthly Recipients*
2005	10,494
2006	10,533
2007	10,944
2008	10,364

Transportation Services

Next to housing, transportation has been repeatedly identified as a significant barrier to community living. Transportation is an important element in keeping elderly and disabled people in touch with community resources, and able to live an otherwise independent life. The variety of transportation available depends on where you reside.

Medicaid-funded medical transportation is ensured for transportation to and from medical services providers for MA-covered services. Payment for medical transportation is authorized only after it has been determined that it is not otherwise available, and then for the least expensive available means suitable to the client's needs. The availability of specialized transportation is limited, especially in rural areas.

Area Agency on Aging transportation programs help older adults maintain their mobility and independence. The programs serve any older adult needing transportation for any reason, however, priority is often placed on those most in need of non-medical transportation who cannot access other available local transportation services.

The vast majority of transportation programs in Michigan are provided by local public transit agencies regulated and funded by the Michigan Department of Transportation (MDOT). Programs are operated in all 83 Michigan counties and include fixed haul, demand response, and specialized services programs. The Specialized Services program provides operating funds to private, non-profit agencies and public agencies providing transportation services primarily to the elderly and persons with disabilities. These programs are supported by federal transportation funds, federal Older Americans Act funds, state funds, and local property tax millage earmarked for transportation programs.

There are at least 57 volunteer driver programs operating in Michigan, in addition to the Michigan Department of Human Service's volunteer driver programs found in most Michigan counties. Many of these programs serve primarily older adults and are found in communities of every size, from metropolitan Detroit to the most rural counties in the state.

Many gaps remain in Michigan's senior and disability transportation network.

- While all counties have some level of transportation service available, in some counties the level is extremely low or is restricted to transportation to meal sites or other very specific programs.
- Lack of coordination among transportation providers can make it difficult to navigate through the multiple transportation agencies in a region to determine which one will provide service.

- Municipal boundaries also pose arbitrary barriers to transportation service. Transportation services often end at town or county lines, even though many of the services seniors need to access may be across the line.
- Seniors are unfamiliar with public transportation and therefore do not use it, and the frail elderly who are most in need of alternatives to driving may not be physically able to access available forms of transportation.

These service shortfalls are largely the result of a lack of funding for transportation services in those areas. In addition, in areas with transportation service, funding from most state sources has remained flat or even decreased in recent years. While there has been a dramatic increase in local transportation funding over the past ten years, the state has not kept pace, especially in public transportation programs. The result is severe funding constraints on many of Michigan's transit systems.

Volunteer driver programs have their own limitations.

- It is difficult to provide accessible transportation using volunteer drivers: few volunteer drivers have lift-equipped vehicles, it is difficult to find an adequate number of volunteers;
- Volunteer driver programs are not designed to transport more than one or two riders at a time; and
- Volunteer driver programs often work best as supplemental programs to public transit systems, used to provide trips to out-county areas where it is too expensive to run a bus, and/or to provide personalized transportation rides for those who are too frail to use public transit.

Energy Assistance

Low Income Energy Assistance Program (LIHEAP)[108]

The Low-Income Home Energy Assistance Program (LIHEAP) provides assistance to disadvantaged households in meeting the costs of home energy. LIHEAP provides three types of energy assistance payments: 1) basic heating assistance, through the Michigan Home Heating Credit; 2) State Emergency Relief (SER) energy services, described in detail later in this section; and 3) weatherization services. In FY 2008, 437,365 low-income households received basic heating assistance; 127,522 received crisis energy assistance; 897 households received energy related home repair services; and 1,114 received weatherization services. Some households may have received more than one of the above LIHEAP services. LIHEAP is available to public assistance households as well as the working poor.

Sources Of Financing
Federal Low-Income Home Energy Assistance Program block grant funds

[108] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs

Program Effectiveness

FY 2007 LIHEAP Activity	Number of Households	Average Payment
Basic Heating Assistance Home Heating Credit	437,365	$145
SER Energy Services Heating and Electric	127,522	$415
Energy-Related Home Repairs	897	$1,067
Weatherization	1,114	$4,332

Federal funding in FY 2008 was $140.6 million. Funding for FY 2009 is $109.3 million higher at $249.9 million. The number of households assisted is expected to increase in FY 2009.

Weatherization Assistance Program (WAP)[109]

The goal of the Weatherization Assistance Program (WAP) is to assist low-income households with reducing their energy consumption and lowering their energy bills. Michigan's WAP is a federally funded, low-income residential energy conservation program. The program provides free home energy conservation services to low-income Michigan homeowners and renters. Community Action Agencies (CAAs) and Limited Purpose Agencies (LPAs) provide weatherization services at the local level throughout the state. Michigan's 30 CAAs and 2 LPA's serve all 83 counties.

Sources Of Financing
Federal Department of Energy Weatherization Assistance Program funds
Federal Health & Human Services Low-Income Home Energy Assistance Program funds
Michigan Public Service Commission award

Program Effectiveness
Weatherized homes typically realize a 20-25% reduction in energy bills. This results in savings of about $300 per year (per household). In the 2007 program year, 4,062 low-income Michigan households received weatherization services. Services provided under the weatherization program may include wall insulation, attic insulation and ventilation, foundation insulation, air leakage reduction, smoke detectors, dryer venting, furnace repair/replacement, water heater repair/replacement, combustion appliance testing, and energy conservation education. To date, over 265,000 low-income homes have been made more energy efficient.

Vocational Rehabilitation

Michigan Commission for the Blind (MCB)[110]

The MCB is a state agency designed to assist persons who are blind to achieve personal, social, and economic independence emphasizing jobs in the competitive labor market. Dollars used for rehabilitation services are an excellent investment in Michigan's future. In FY 2008, the Michigan Commission for the Blind successfully closed 225 blind Michigan residents' cases. Of these, 175 people found jobs in competitive employment, with an average starting wage of $12.96 an hour. The state and federal income tax paid by these individuals is projected to be $812,668 in FY 2009. The $1 million investment made by MCB to assist these individuals with employment will be recovered in approximately 15 months.

[109] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs
[110] 2008 Annual Report, Michigan Commission for the Blind

During FY 2008, the MCB served approximately 3,500 blind or visually impaired individuals to assist them in becoming employed and independent. In addition to the 175 employed individuals mentioned previously, nearly 1,400 older individuals facing loss of sight received independent living services from the MCB so they could remain in their homes and communities, and more than 400 blind youth in the K-12 system received low vision evaluations and aids to help them succeed in school and beyond.

Michigan Commission for the Blind Independent Living Program

The **MCB Independent Living Program** is for individuals who are legally blind and age 55 or older, and want to continue living at home as self-sufficiently as possible. Depending on the individual, training may include learning to use some or all of these skills and resources:

- Orientation and Mobility
- Adaptive Kitchen Skills
- Communications
- Home Maintenance and Management
- Time and Money
- Personal Management
- Leisure Activities
- Peer Support
- Low-Vision Devices
- Information and Referral
- Additional Disabilities
- Vocational Rehabilitation Program

MCB's training and other services can be provided in the home, at the residential Michigan Commission for the Blind Training Center in Kalamazoo, and/or at a week-long Mini Adjustment Seminar held at various locations around the state as an introduction to the MCB Training Center. The MCB Training Center serves approximately 400 people each year age 16 and older who are participating in MCB programs, including the Independent Living Program. Staff are trained and experienced in working with people who are blind or visually impaired. All services, including room and board, are provided at no cost to those attending the center. Length of stay at the MCB Training Center is based on individual goals

The MCB Independent Living Program is funded through state and federal funds.

Commission on Disability Concerns

The Michigan Commission on Disability Concerns responds to and advocates on behalf of an estimated 1.9 million people with disabilities in Michigan. It is the only state agency with the statutory responsibility to advocate on behalf of all people with disabilities in Michigan. Commission staff provides a variety of education and advocacy services, technical assistance, disability rights training, civil rights laws, as well as a statewide information and referral service on a wide range of disability issues.

The Division of Deaf and Hard of Hearing located within the Commission has three primary functions: serve as an advocate for the deaf and hard of hearing population of the state, offer state qualification of interpreters, and provides a variety of technical assistance services.

Services of the Michigan Commission on Disability Concerns are available to all state residents and can be obtained by calling a single statewide toll-free number (voice or TTY).

Other Services

Emergency Relief Program (SER)[111]

The State Emergency Relief Program (SER) assists individuals and families to obtain safe, decent and affordable shelter and other essentials when they face an emergency due to factors or conditions beyond their control. The FY 2009 budget appropriates $41.8 million for this program. All persons (other than illegal aliens) are potentially eligible for SER, with no residency requirements. The SER applicant group must be physically present in Michigan at the time of application, must have an emergency that threatens their health or safety, and the emergency must be resolvable through issuance of SER. SER is not issued to resolve applicant-created emergencies. Covered services include:

- Relocation: provides money for rent, security deposits, and moving expenses
- Home Ownership: house payments, property taxes, homeowner's insurance and mobile home owner's lot rent, up to a lifetime limit of $2,000, to prevent loss of a home if no other resources are available and the home will be available to provide safe, affordable shelter in the foreseeable future
- Home Repairs: up to a lifetime limit of $1,500 for energy-related repairs (furnace repair/replacement) and $1,500 for non-energy-related repairs, to correct unsafe conditions and to restore essential services
- Utility Assistance: restoration or shut off prevention of water and cooking gas service (up to a fiscal year cap of $175) and utility deposits and reconnection fees (up to $200 per occurrence) when service is necessary to prevent serious harm
- Burial: payments are authorized for burial or cremation when the deceased person's estate and contributions from friends or relatives are not sufficient to pay for burial or cremation (there is a $4,000 limit on voluntary contributions from friends or relatives over and above the SER payment)
- Heating Fuel and Electricity: assistance is provided under the Low-Income Home Energy Assistance Program (LIHEAP) with yearly limits changing based on available funding

Sources Of Financing
Federal TANF funding
State funding for all families with children not eligible for TANF funding and all other childless couples and single adults

Program Effectiveness
In FY 2008, a monthly average 7,917 recipients received SER assistance.

Type of Assistance	Expenditures
Utilities/Deposits	229,864
Home Repairs	1,015,180
Water	1,810,438
House Payments/Property Tax	1,440,000
Rent/Mobile Home Rent	7,020,560
Insurance	8,740
Household Items/Food/Other	1,142
Burials	9,054,217
Emergency Services Contract	7,601,048
Food Bank Council	675,000

[111] Department of Human Services, Program Descriptions, FY 2010; www.michigan.gov.dhs

Arab Chaldean Council/ACCESS Contracts	1,715,500
Salvation Army-Emergency Shelter Contract	11,649,700

Physical Disability Services (PDS)

Physical disability services (PDS) are those necessary services and expenditures targeted for medically stable persons 18 years of age or older who have functional limitations which are physical in nature. Expenditures may be authorized in the following areas:

- Assessment
- Training
- Counseling
- Clinical Services
- Equipment aids
- Mobility devices
- Communication aids
- Home modifications
- Vehicle modifications
- Adjunct services

Services are provided to enable functionally limited people to live as independently as possible. Persons eligible for these services are medically stable and mentally capable of participating in services planning.

Eligibility Factors

Eligibility is based on four criteria: Medicaid eligibility, age 18 years or older, certification of physical disability, and necessary services. A consumer must meet all four criteria and be an active ILS case (see DHS Home Help Program, Section 3) before PDS is authorized.

Program Effectiveness

Physical Disability Services Expenditures FY2000 – FY2006[112]

Fiscal Year	*Expenditures*
2000	1,344,816
2001	1,292,549
2002	1,289,758
2003	971,945
2004	1,133,268
2005	1,266,854
2006	1,188,881

Medical Transportation

Financial support is ensured for round-trip transportation to obtain medical evidence or receive any MA-covered service from any MA-enrolled provider including chronic and ongoing treatment, prescriptions, medical supplies, and one-time occasional and ongoing visits for medical care. The availability of specialized transportation is limited, especially in rural areas. Payment may be authorized only after it has been determined that it is not otherwise available, and then for the least expensive available means suitable to the client's needs.

[112] Michigan Department of Human Services, Information Packet, June 2007

Office of Services to the Aging[113]

Volunteer Programs[114]

For 30 years, the State of Michigan has recognized the tremendous health benefits associated with regular volunteer activity, while also investing in the skills, experiences and talents of its older adult population as a resource to meet diverse community needs. In 2008, more than $5.6 million in state funding was administered by the Office of Services to the Aging (OSA) to support three volunteer programs: the Retired and Senior Volunteer Program (RSVP), the Foster Grandparent Program (FGP) and the Senior Companion Program (SCP). These three programs are designed to encourage and support the desires of older adults to remain involved in community life and service. Michigan also receives federal funds for these programs through the Federal Volunteer Agency, the Corporation for National and Community Service.

Foster Grandparent Program

The FGP represents one of the most successful models of intergenerational programming nationwide. It provides opportunities for low-income men and women, age 60 and older, to assist children and youth who need personal attention and assistance in schools, hospitals, juvenile detention facilities, day care centers, community programs, and private homes. Foster grandparent volunteers are involved in mentoring and tutoring. They offer emotional support to child victims of abuse and neglect, and they care for premature infants and children with physical disabilities and severe illnesses. Foster grandparents receive a stipend of $2.65 per hour, transportation assistance, training, and volunteer insurance. Currently, 19 Foster Grandparent Programs serve 59 Michigan counties.

Senior Companion Program

The SCP offers low-income men and women, age 60 and older, the opportunity to provide individualized care and assistance to older adults and others with developmental disabilities, Alzheimer's disease, mental illness and conditions that make them frail and at-risk. Senior companion volunteers add richness to the lives of those they serve. They also support other alternative care services funded by OSA, such as care management and respite, which allow older adults to remain living in their own homes. During 2008 there were 14 Senior Companion Programs operating in 47 Michigan counties.

Retired and Senior Volunteer Program

The RSVP provides opportunities for people, age 55 and older, to serve their communities, explore new interests, and stay active. Volunteers serve without payment, but receive transportation assistance, volunteer insurance, training, and recognition. RSVP volunteers provide services in areas such as tutoring, literacy, public safety, homeland security, healthcare, and economic development. These are provided through 22 local projects in 40 Michigan counties. Approximately one-half of Michigan's RSVP volunteers support services for other older adults in critical areas such as home delivered meals, long term care, benefits counseling and elder abuse prevention.

[113] Michigan's Senior Transportation Network, An Analysis of Transportation Services for Older Adults in Michigan, November, 2005
[114] Ibid

APPENDIX B - STAKEHOLDERS RECOMMENDATIONS

The State Profile Tool Advisory Council provided input to the report through a series of seven meetings. The Council would meet on a Thursday afternoon for a presentation by a department on their long-term care responsibilities. On Friday morning, the Council would discuss each presentation and provide input as to their recommendations for improvement. Many of these recommendations are integrated throughout the body of the Profile Tool. The following is a partial list of the Council's most important recommendations.

Section 2 - System Administration and Management

- Throughout the section, emphasize the need for system-wide cultural competency including: memory care, LGBT and gender identity, race and ethnicity, tribes, disability culture and family traditions.

Bureau of Health Systems
- Change the organizational from a medical to a social model.
- Revise the internal review process for consumer complaints to assure prompt investigation and resolution.
- Require notification of voluntary closures
- Require state closure team involvement in all closures, involuntary and voluntary.
- Close nursing facilities that are sanctioned year after year.

Office of Long-Term Care Supports and Services
- Expand the SPE system to serve all people in Michigan
- Continue efforts to coordinate all LTC policies, programs, and practices.

Section 3: Older Adults and Persons with Disabilities

Programs and Services – Medical Services Administration
- Raise the protected income level
- Correct Medicare policy that impacts the timeliness and availability of service delivery for consumers who are dually enrolled.
- Address the lack of providers who accept Medicaid.
- Create an external advocacy system to assist consumers who have unmet health and long-term care needs to navigate the complicated and confusing system

Programs and Services – Office of Services to the Aging
- Create an appeals process within the aging network service system that includes access to an external advocate.
- Increase the availability of day programs for people with dementia who are living with their family.
- State Long Term Care Ombudsman Program:
    - Increase staff to meet the recommended standards of AARP's Public Policy Institute.
    - Expand the program to include both nursing home and community based services.
    - Create one program that is external to state government.

Programs and Services – Department of Human Services (DHS)
- Create an external advocate to assist consumers to understand their rights.
- Resolve coordination issues that exist between eligibility and adult services.
- Assure consistency in services from one county to another.

Programs and Services – Centers for Independent Living (CIL)
- Find people jobs that enable them to be independent of the service system.
- Assure all areas of the state have a local CIL.

Section 4: Services for People with Developmental Disabilities

- Improve coordination of services for people with DD in nursing homes.

Section 5: Persons with Mental Illness

- End the policy that allows CMH to claim no responsibility (CMH carve out) to bring people home when they place people with mental illness in nursing homes.

Section 7: Unique Populations

Veterans
- Infuse PCP into veteran's LTC system.
- Simplify the layers of bureaucracy veterans must endure to obtain LTC services.

Dementia
- Assure consistent access to resources across the state
- List Dementia on medical records as a co-morbid diagnosis, after an accurate assessment.
- Increase the competency of professional staff and care givers by making available training throughout the state.

Persons in Correctional Facilities
- Coordinate discharge of prisoners to nursing homes with the Office of Long-term Care Supports and Services.
- Stop the discharge of prisoners to bad nursing homes (those the LTC Ombudsman is investigating and preparing to close).
- Question if nursing homes use the $13,000 incentive to accept a prisoner to meet the unique needs of that person.
- Create LTC accessible units that include the possibility of parole.
- Adjust the medication distribution system so prisoners who need medication more than twice a day can receive their meds in the prescribed manner, and for prisoners who cannot stand an extended period of time.
- Orthopedic shoes should follow the prisoner, where ever they are assigned.

Members of Native American Tribes
- Offer incentives to local service organizations (AAA, SPE, CIL) to build relationships with tribal members and tribal organizations.

Section 8 Other Issues Impacting Long-Term Care

Issue Two: Housing
- Increase the stock of affordable, accessible, integrated housing.
- Expand the definition of "family" to include a family of one.
- Increase the number of Section 8 Home, not site, based Vouchers targeted to people with disabilities.
- Increase the number of Choice Vouchers for nursing home transition.
- Track existing and new site-based vouchers, designated for people with disabilities, to assure they are being used as intended. Clearly indicate the requirements for filling accessible units and identify the person who oversees the program.

APPENDIX C - MICHIGAN'S LONG-TERM CARE TASK FORCE REPORT - EXECUTIVE SUMMARY

The Michigan Medicaid Long-Term Care Task Force, appointed by Governor Jennifer Granholm, met between June 2004 and May 2005. It was charged with the duty to examine the long-term care (LTC) system and make recommendations to improve quality, expand the reach of home- and community-based services, and reduce barriers to an efficient and effective continuum of LTC services in Michigan. The task force responded by adopting a mission statement that emphasizes the role of consumer choice and by recommending the following policy changes:

1. Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities.
2. Improve access by establishing *money follows the person* principles that allow individuals to determine, through an informed choice process, where and how their LTC benefits will be used.
3. Designate locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services.
4. Strengthen the array of LTC services and supports by removing limits on the settings served by MI Choice waiver services and expanding the list of funded services.
5. Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.
6. Promote meaningful consumer participation and education in the LTC system by establishing a LTC Commission and informing the public about the available array of options.
7. Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of long-term care.
8. Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable LTC workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.
9. Adopt financing structures that maximize resources, promote consumer incentives, and decrease fraud.

The goal of these recommendations is to create an integrated system that appears seamless to the consumer, yet takes maximum advantage of the variety of LTC programs at the local, state, and federal levels. Specific recommendations for reducing barriers to an efficient and effective LTC system include expanding eligibility criteria, creating reimbursement mechanisms based on the acuity level of the consumer, and centralizing supports coordination in the SPE. Citizens will be better informed, involved, and prepared for their LTC needs through public education, participation in statewide and local commissions, and through financial incentives. The state will be better organized by centralizing its LTC planning and administration functions, which are currently scattered across departments.

Appended to this report is a Model Act, which is tentatively titled the “Michigan Long-Term Care Consumer Choice and Quality Improvement Act.” It was drafted by a workgroup that sought to embody the task force’s ideas in single document that may serve as a basis for legislative action. Although the task force recommendations may be enacted through a variety of means, the model act reinforces the idea that a cohesive, ongoing, and purposeful framework for the provision of LTC is needed in the state.

APPENDIX D - GLOSSARY

Acronym		Definition
AAL	Affordable Assisted Living	A program to partner apartment style housing with Medicaid services for persons who can no longer remain home but do not need and/or desire the more costly nursing home placement.
AAA	Area Agency on Aging	Regional planning, advocacy and administrative agencies that plan and provide needed services in specified geographic regions of the state. AAAs contract for in-home and community support services for older adults and qualified disabled adults.
ACP	Adult Community Placement	Assistance in locating and selecting licensed community care facilities for people 18 years of age and older who can no longer live independently. Available to individuals who require placement based on functional assessment regardless of Medicaid eligibility.
APS	Adult Protective Services	Provides protection to vulnerable adults (18 years and older) who are at risk of harm due to the presence or threat of abuse, neglect, or exploitation. Administered by the Department of Human Services.
ADL	Activities of Daily Living	Activities that all people generally do habitually and universally, such as eating, bathing, dressing, grooming, toileting, transferring, mobility.
	Advocate	A person who speaks or writes in support of another person.
AFC	Adult Foster Care	AFCs provide 24-hour personal care, protection, and supervision to individuals not capable of independent living but not in need of continuous nursing care. Services include assistance with basic activities of daily living such as bathing, dressing, toileting, and eating. Services can also include management of existing medical conditions requiring special diets, medications, and basic medical care short of continuous or extensive skilled nursing care. AFC homes are limited to providing care to no more than 20 adults. These facilities must be licensed.
ADRC	Aging and Disability Resource Center	A comprehensive resource on long-term care that provides information and assistance in accessing services, planning for long-term care financing and delivery, benefits outreach and choice counseling for the general population. The ADRC will conduct medical and facilitate financial eligibility for Medicaid funded supports and services provided in nursing facilities and the MI Choice waiver.
	Assessment	The process of collecting in-depth information about a person's situation and functioning to identify individual needs in order to develop a comprehensive case management plan. In addition to direct consumer contact, information should be gathered from other relevant sources.
AoA	Administration on Aging	The nation's information resource for home- and community-based care for older persons and their caregivers.
APS	Adult Protective Services	The division within the Department of Human Services that investigates allegations of abuse, neglect or exploitation and provides protection to vulnerable adults.
	Assisted Living	Assisted Living is part of the continuum of long-term care services that may provide a combination of housing, personal services, and health care designed to help individuals who need assistance with normal, daily activities (sometimes referred to as "Activities of Daily Living" or "ADLs") in a manner that promotes the person's independence. Assisted Living differs from nursing home care in that Assisted Living does not provide the 24-hour skilled nursing care offered in licensed nursing homes. Nursing homes and Assisted Living communities operate under entirely different sets of rules and

Acronym		Definition
		regulations. The level of services and/or types of care offered varies widely
	Benefits Counseling	The provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medigap policies), SSI, Food Stamps, Medicare, Medicaid and private pension benefits
BHS	Bureau of Health Systems	The Bureau of Health Systems is responsible for assuring that individuals and facilities providing health care services function in a safe and effective environment for the protection of the citizens of Michigan.
	Caregiver	The person responsible for hands-on care for a consumer
CIL	Center for Independent Living	Centers for Independent Living (CILs) are grassroots, advocacy-driven organizations run by and for people with disabilities. They focus on civil rights, the independent living philosophy, and inclusion
CM	Care management	A collaborative process that assesses, plans, implements, coordinates, monitors, an devaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. Also called case management, supports coordination.
CWP	Children's Waiver Program	Provides home and community-based children under age 16 who would require care in an Intermediate Care Facility for the Mentally Retarded without the waiver.
CMS	Center for Medicare and Medicaid Services	The federal Department of Health and Human Services agency responsible for administration of Medicare and Medicaid programs.
CMHSP	Community Mental Health Services Program	The entity responsible, at the local level, for provision of publicly-funded mental health services.
	Community Support	Community support home care services include meals on wheels, transportation, friendly visitor, emergency response system, delivery services, and health screening clinics
CON	Certificate of Need	A Certificate of Need (CON) program is established by state law. It prohibits identified health facilities, services, or equipment from being initiated, upgraded or modernized, expanded, relocated, or acquired without a certificate from that state determining the facility, service, or equipment is needed.
COD:IDDT	Co-occurring disorders: integrated dual disorder treatment	An approach that helps people recover by offering treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter.
CPS	Child Protective Services	The purpose of CPS is to ensure that children are protected from further physical or emotional harm caused by a parent or other adult responsible for the child's health and welfare and that families are helped, when possible, to function responsibly and independently in providing care for the children for whom they are responsible.
CTF	Consumer Task Force	This is a group of people with a common interest in improving the Medicaid Program. They are people with disabilities, people who are elderly, family members, and advocates. State staff also helps on an "as needed" basis and helps the Task Force meetings. Members have a common interest in improving services for Michigan's citizens, specifically around long-term care, supports, and issues with work. The Task Force is led by a consumer.
CoA	Council/Commission on Aging	Agencies that provide services to seniors residing within a geographic region. Generally created through a governmental authority such as a county commission. Most of counties in Michigan have at least one council or commission on aging.

Acronym		Definition
	Commission on Services to the Aging	The Commission on Services to the Aging consists of 15 members appointed by the governor with the advice and consent of the Senate. In addition to advocacy for senior citizens, the commissions responsibilities include reviewing and approving grants administered by the Office of Services to the Aging; designating planning and service areas and area agencies on aging within each planning and service area; and participating in the preparation and approval of the state plan and budget required by the federal Older Americans Act of 1965.
	Consumer	An individual seeking or receiving public assistance.
	Consumer Direction (Self Direction)	Describes programs and services where consumers have maximum choice and control over their care, often using vouchers or cash payments for the cost of services. In contrast to having care managers arrange services for clients, consumer directed care allows individual consumers to assess their own needs, determine how those needs should be met, and monitor the quality of the services they receive.
	Cultural Competency	A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.
DCH	Department of Community Health	The Michigan department responsible for health policy and management of the state's publicly-funded health service system.
	Direct Care Worker	Provide hands-on long-term care and personal assistance received by citizens who are elderly, chronically ill, or physically disabled
DD	Developmental Disability	A disability which originates before age 18, can be expected to continue indefinitely, and constitutes a substantial handicap to the individual's ability to function normally.
DELEG	Department of Energy, Labor, and Economic Growth	The Michigan department charged with promoting economic and workforce development, stimulating job creation, and enhancing the quality of life in Michigan.
DHHS	Department of Health and Human Services	Federal agency that administers many of the social programs dealing with the health and welfare of the U.S. citizens. DHHS is the parent agency of CMS.
DHS	Department of Human Services	The government agency responsible for public assistance and child and family welfare. Directs the operations of public assistance and service programs through a network of over 100 county offices around the state. Formerly the Family Independence Agency.
DOC	Department of Corrections	The government agency responsible for adult prison, probation, and parole systems in Michigan.
DOE	Department of Education	The government agency responsible for carrying out the policies of the State Board of Education and implementing federal and state mandates in education.
DOT	Department of Transportation	The government agency responsible for highway and transportation services in Michigan.
	Environmental Modifications	Physical adaptations to the home and/or work place, required by the individual's support plan, that are necessary to ensure the health, safety and welfare of the individual, or enable functioning with greater independence within the environment.
FAP	Food Assistance Program	The purpose of the Food Assistance Program (FAP) is to raise the food purchasing power of low-income persons because limited food purchasing power contributes to hunger and malnutrition. Groups of persons eligible for FAP, receive benefits based on net income and the size of the group, to increase the food purchasing power of the group.

Acronym		Definition
FNS	U.S. Department of Agriculture, Food and Nutrition Services	Provides children and low-income people access to food, a healthful diet, and nutrition education
FTW	Freedom to Work	The Freedom to Work law allows persons with disabilities who work to increase earnings and savings and still keep Medicaid coverage
FY	Fiscal Year	For Michigan: October 1 – September 30
	Functional Limitation	The extent to which a person is physically incapable of performing activities essential for self and home care.
GF/GP	General Fund/General Purpose	The state matching monetary amount for Medicaid services and other non federally-funded activities.
	Grants	Direct cash outlays to state or local governmental units, to other public bodies established under state or local law, or to their designee.
	Group Home	(Also called adult care home or board and care home.) Residence which offers housing and personal care services for 3 to 16 residents. Services (such as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home. (Licensed as adult family home or adult group home.)
	Guardian	A person either appointed by a court or designated by a will to exercise powers over the person of an individual who is less than 18 years of age or legally incompetent person.
	Habilitation/Supports waiver	Provides home and community-based services to developmentally disabled persons over age 18, who, but for the waiver, would require care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)
HCAM	Health Care Association of Michigan	The trade association representing Michigan's long-term care providers and rehabilitation facilities. Membership includes skilled nursing facilities, county medical care facilities and assisted living facilities in both the profit and non-profit entities.
HCBS	Home and Community Based Services	Section 2176 of the Omnibus Reconciliation Act permits states to offer, under a waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as community and home-based services which may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services.
HFA	Home for the Aged	Provides 24-hour room, board and supervised personal care to 21 or more unrelated, non-transient individuals 60 years of age or older. Also refers to home for 20 or fewer individuals 60 years of age or older that is operated in conjunction with and as a distinct part of a licensed nursing home.
HH	Home Help Program	Medicaid state plan optional service that provides assistance in conducting activities of daily living.
	Home Heating Credit	A tax credit funded by federal LIHEAP grants that helps low income families pay home heating costs.
I&A	Information and Assistance	Comprehensive, objective, up-to-date, citizen-friendly, information that covers the full range of available long-term care options, options that people will use immediately (such as Medicaid services) to long-range options (such as private long-term care insurance), and cover programs and services that support family caregivers, as well as any special options in the state to maintain independence or direct one's own long-term support service. Assistance to accessing these options must be available.
I&R	Information and Referral	The provision of information (see I&A) and referral of individuals to

Acronym		Definition
		other programs and benefits that can help them remain in the community, including programs that can assist a person in obtaining and sustaining paid employment.
	Informed Choice	A thoughtful decision based on an accurate understanding of the full range of options and their possible results.
IADL	Instrumental Activities of Daily Living	Activities that concern a person's ability to adapt to or function in his environment, such as laundry, housework, meal preparation, taking medication, shopping and light housework.
	Independent Living	Free from the influence, guidance, or control of another or others. Being in control of your own life, taking responsibility for your actions, taking risks, and either failing or succeeding on your own terms. It means participating in community life and pursuing activities based entirely upon self-determined interests and preferences.
ICF/MR	Intermediate Care Facility for the Mentally Retarded	A facility that provides care and treatment for individuals that are developmentally disabled. Michigan has one remaining ICF/MR that is in the process of being closed.
LIHEAP	The Low Income Home Energy Assistance Program	Federal funds allocated to states to assist low-income families with energy costs.
LIHTC	Low Income Housing Tax Credit	A tax credit created under the Tax Reform Act of 1986 that gives incentives for the utilization of private equity in the development of affordable housing aimed at low-income Americans
LOC	Level of care	Amount of assistance required by consumers which may determine their eligibility for programs and services. Levels include: protective, intermediate, and skilled.
LOCD	Level of care determination	Determination of an individual's functional abilities and need for long-term care services
LTC	Long-term care	Services and supports provided to an individual in a setting of his/her choice that are evaluative, preventive, habilitative, rehabilitative or health related in nature.
LTCC	Long-Term Care Connections	See single point of entry (SPE)
LTCI	Long-term care insurance	An individual or group insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes individual or group annuities and life insurance policies or riders that provide directly or supplement long-term care insurance.
LTCTF	Michigan Medicaid Long Term Care Task Force	Appointed by Governor Granholm to examine the long term care system and make recommendations to improve quality, expand the reach of home and community-based services, and reduce barriers to an efficient and effective continuum of LTC services. The LTCTF reported out with nine recommendations which have shaped the template of LTC systems change in Michigan.
	Managed care	A healthcare delivery approach that aims to reduce unnecessary care and control costs by using gatekeepers who determine the medical care, both general and specialized, that a patient should get, or the range of providers that can be used.
MA	Medicaid	The program for medical assistance established under Title XIX of the Social Security Act, Chapter 531, Stat. 620, 42 USC 1396 to 139f, 1396g-l to 1396r- 6, and 1396r-8 to 1396v, and administered by the department under the Social Welfare Act, 1939 PA 280, MCL

Acronym		Definition
		400.1 to 400.119b. Provides healthcare and/or long term care coverage for more than 1.5 million Michigan residents. Services covered include inpatient and outpatient hospital services, physician services, health screening for eligible children, maternity services, pharmacy, medical supplies and equipment, nursing, mental health care, long term care, and other services.
MAHSA	Michigan Association of Homes and Services for the Aging	The trade association that represents the state's not-for-profit senior housing, services and care providers. Members include home and community-based services, government subsidized and market rate housing, assisted living, homes for the aged, adult foster care, county medical care facilities, hospital long-term care units and nursing homes.
MALA	Michigan Assisted Living Association	A nonprofit organization representing 4200 assisted living, residential and vocational services programs.
MC	Medicare	The federal program providing hospital and medical insurance to people age 65 and older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited. Title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc. See Title XVIII
	Medicare Part D	Medicare prescription drug/pharmaceutical coverage.
MCO	Managed care organization	The organization that serves as the gatekeeper to a healthcare system that integrates the financing and delivery of health and/or long term care services to covered individuals.
MDRC	Michigan Disability Rights Coalition	MDRC is a statewide network of individuals and organizations that advances the issues of Michigan's disability community through grassroots activism, public education and advocacy.
MDS	Minimum Data Set	The core assessment items necessary for a comprehensive assessment of a nursing home resident. This includes individual assessment items and specifies definitions, time frames, and exclusions for the items as well as the response codes needed to ensure accurate assessment. It covers a wide rage of functional domains, such as the resident's status in terms of cognition, communication, activities of daily living, continence, psychosocial wellbeing, disease diagnoses, and health conditions.
MDS-HC	Minimum Data Set-Home Care	The core assessment items necessary for a comprehensive assessment of a home care consumer. In Michigan, the MDS-HC is used to assess participants in the MI Choice waiver program.
MFP	Money Follows the Person	A system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change.
	MI Choice	Michigan's 1915(c) home and community-based services waiver for the elderly and physically disabled
MHSAA	Mental Health and Substance Abuse Administration	Carries out responsibilities specified in the Michigan Mental Health Code, the Michigan Public Health Code and administers Medicaid Waivers for people with developmental disabilities, mental illness, serious emotional disturbance and substance disorders. Part of the Department of Community Health.
	Michigan Regional Skill Alliances	Employer-driven organizations that address the workforce issues and needs within their local areas through the Department of Labor and Economic Growth.
	Michigan Long-Term Care Connections	See single point of entry (SPE)

Acronym		Definition
MMAP	Medicare/Medicaid Assistance Program	Michigan MMAP is a statewide health insurance education counseling and assistance program which responds to the concerns of seniors regarding Medicare, Medicare + Choice managed care, Medicaid, supplemental insurance, long-term care insurance, Medicare and Medicaid funds for long-term care, and other related benefits issues. Direct counseling services are provided by volunteers trained to help seniors understand the increasing complexities of health care coverage. Service is provided at senior citizen centers, churches, community centers, over the phone, and through home visits for those individuals with mobility limitations.
MPHI	Michigan Public Health Institute	A consulting firm that contracts with the State for research purposes.
MQCCC	Michigan Quality Community Care Council	The Michigan Quality Community Care Council (QC3) is a public body formed to help make sure that home care workers are available for consumers. Consumers may find a provider from a list (called the Registry) the QC3 will have. Home Help consumers will still be able to find, hire, train, and fire their in-home care provider. The QC3 may also help by assisting providers in getting training.
MPAS	Michigan Protection and Advocacy Services	A private, non-profit organization designated by the Governor to protect and promote the human and legal rights of people with disabilities in Michigan.
MRS	Michigan Rehabilitation Services	MRS helps Michigan residents with disabilities achieve employment and self-sufficiency. It serves people in their communities through a network of field offices staffed by rehabilitation counselors.
MSA	Medical Services Administration	The agency within the Department of Community Health that is responsible for administration of the Medicaid program. MSA is the designated single state Medicaid agency.
MSHDA	Michigan State Housing Development Authority	Provides financial and technical assistance through public and private partnerships to create and preserve decent, affordable housing for low- and moderate-income Michigan residents.
NAPIS	National Aging Programs Information System	A reporting procedure developed by AoA for use by State and Area Agencies on Aging.
	Nursing Facility	Facility licensed by the state to offer residents personal care as well as skilled nursing care on a 24 hour a day basis. Provides nursing care, personal care, room and board, supervision, medication, therapies and rehabilitation. Facilities are licensed as nursing homes, county homes, or nursing homes/residential care facilities.
NFT	Nursing Facility Transition	A program that identifies consumers in institutions who wish to transition to the community and helps them to make the necessary arrangements to do so.
OAA	Older Americans Act	Federal legislation that specifically addresses the needs of older adults in the United States. Provides funding for services such as home delivered meals, congregate meals, senior center, employment programs for individuals age 60+. Creates the structure of federal, state, and local agencies that oversee aging services programs.
OC	Options counseling	Unbiased guidance that helps consumers explore options, plan for and access long term care services and supports. OC assists consumers to set goals, make choices, and plan services in keeping with their own individual strengths, needs and resources.
OLTCSS	Office of Long-Term Care Supports and Services	The office within the Department of Community Health that administers activities to implement the recommendations of the Long-Term Care Task Force, coordinates state planning for long term care supports and services, reviews and approves LTC policy, conducts quality assurance review of publicly-funded LTC programs, and oversees implementation of the SPE demonstrations projects.

Acronym		Definition
OMA	Older Michiganians Act	PA 180 of 1981 as amended. An Act to create a commission on services to the aging within the executive office of the governor; to create an office of services to the aging as an autonomous entity within the department of management and budget; to authorize the designation of area agencies on services to the aging and to prescribe their powers and duties; to establish certain programs relating to older persons; to prescribe the powers and duties of certain state departments, officers, and agencies; to create funds; to provide penalties; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates. Transferred to the DCH in 1997.
OSA	Office of Services to the Aging	Designated state unit on aging. Coordinates and administers all state activities related to older persons in accordance with the requirements of the federal Older Americans Act and the state Older Michiganians Act. Establishes service standards, provides information, education and assistance to elders, caregivers and families. Targets services to elders who are frail, low income and at risk of losing their independence. Delivers services through a network of innovative public/private partnerships that include area agencies on aging and hundreds of local service providers.
	Ombudsman Program	The Long-Term Care Ombudsman Program is a system of state and local advocacy services designed to address issues and problems faced by residents of licensed long-term care facilities. Housed within the OSA, Michigan's Long-Term Care Ombudsman assists residents of nursing homes, homes for the aged, adult foster care homes, and their families and friends who have questions and complaints. Ombudsmen can also provide information about the Medicare and Medicaid systems and information about LTC policy and government regulations. In addition ombudsman staff can explain the different kinds of care, how to find it, how it is paid for and information on specific facilities.
PACE	Program of All-Inclusive Care for the Elderly	A capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals that meet long-term care level of care criteria. For most PACE participants, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized.
PCP	Person-Centered Planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professional as the individual desires or requires.
PDS	Physical Disability Services	Necessary services and expenditures targeted to medically stable persons 18 years of age or older that have functional limitations which are physical in nature.
PERS	Personal Emergency Response Systems	Electronic devices, designed to monitor safety that enable individuals to secure help in the event of an emergency. PERS generally involve a portable help button to allow for mobility. The system is connected to the user's telephone and programmed to signal a response center once the help button is activated. Also known as a Medical Emergency Response System.
PES	Participant Experience Survey	A series of population-specific interview tools that capture data that can be used to calculate indicators for monitoring quality within the waiver programs. Each survey is designed to be conducted as a face-to-face interview.

Acronym		Definition
PIHP	Prepaid Inpatient Health Plan	Community-based mental health, substance abuse and DD specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP). To be an approved Medicaid provider, a PIHP must be certified as a Community Mental Health Services Program (CMHSP) by DCH in accordance with Section 232a of the Michigan Mental Health Code. A PIHP may be either a single CMHSP, or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel. PIHPs must be enrolled with DCH as Medicaid providers. The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in this manual.
POSM	Participant Outcome Survey Measures	A quality of life survey instrument to be used in long-term care programs. The instrument addresses area such as the availability of paid supports, relationships with support workers, meaningful activities, community integration, personal relationships, dignity and respect, autonomy, privacy and security.
PSA	Planning and Service Area	The geographic area, consisting or one or more counties, for which an agency is designated to plan for and provide services under the Older Americans Act.
	Provider	A person or agency that furnishes a service to a consumer.
QA	Quality Assurance	The use of activities and programs to ensure the quality of patient care. These activities and programs are designed to monitor, prevent, and correct quality deficiencies and noncompliance with the standards of care and practice.
QAAP	Quality Assurance Assessment Program	A fee placed on licensed nursing facility beds for all non-Medicare days of care rendered. The fee is based on the total number of patient days of care from the preceding year and is assessed at a uniform rate on October 1 of each year. The QAAP fee is payable to the State on a quarterly basis.
	Quality Framework	Federally created and approved quality components that provide a uniform nationwide format that enables states to describe the key components of the state's quality assurance/quality improvement program in a consistent and standard manner. The focus is on participant access, participant service planning, provider capacity, participant safeguards, rights and responsibilities, outcomes and satisfaction, and system performance.
	Quality Indicators	Quality measures that provides information about how well a provider renders care for some of their patients. The measures provide information about patients' physical and mental health, and whether their ability to perform basic daily activities is maintained or improved. Quality information can be used to help compare providers.
	Quality Improvement	An array of techniques and methods used for the collection and analysis of data gathered in the course of current health care practices in a defined care setting to identify and resolve problems in the system and improve the processes and outcomes.
	Residential Care	The provision of room, board and personal care. Residential care falls between the nursing care delivered in skilled and intermediate care facilities and the assistance provided through social services. It can be broadly defined as the provision of 24-hour supervision of individuals who, because of old age or impairments, necessarily need assistance with the activities of daily living.

Acronym		Definition
RSA	Regional Skills Alliance	Initiatives to support employers and economic development needs by providing training to fill job vacancies in high demand fields that will bolster further economic growth.
RSDI	Retirement, Survivors and Disability Insurance	RSDI is a program administered under Title II of the Social Security Act through the SSA that pays benefits to persons who have contributed enough quarters to the Social Security system, or who are the dependents of one who has contributed to the system, when they are aged or retired, are a surviving spouse or dependent child, or are disabled. An individual under age 65 receiving RSDI as a retired person must be determined disabled to be eligible.
SD	Self Determination	Self-determination is the freedom to make individual choices about one's own life and the opportunity to fail, just like any other person.
SER	State Emergency Relief	SER provides a wide range of emergency services. SER provides services such as payment for heating fuel, electricity and home repairs. Eligibility is based on a number of factors.
SILC	Statewide Independent Living Council	The SILC is an autonomous, independent body representing people with significant disabilities across the entire state and the interests of centers for independent living and others. It is to be a planning body and to work effectively with the state's vocational rehabilitation agency and, if you have one, blind services agency as well.
SLTCO	State Long-Term Care Ombudsman	The individual designated by the state as responsible for investigating and resolving complaints made by or for older people in long-term care facilities. Also responsible for monitoring federal and state policies that relate to long-term care facilities, for providing information to the public about the problems of older people in facilities, and for training volunteers to help in the ombudsman program. The long-term care ombudsman program is authorized by Title III of the Older Americans Act.
SPE	Single Point of Entry	Access points for individuals seeking long term care. Michigan's SPEs provide comprehensive information and assistance services and options counseling to help consumers learn about, understand and explore options, as well as to plan for and access long term care services and supports. SPEs facilitate the person-centered planning process with consumers, conduct functional eligibility determination, coordinate financial eligibility determination, facilitate nursing facility transitions, and serve as Michigan's entry point into Medicaid-funded long-term care services. The SPEs were eliminated effective June 1, 2009 due to severe and ongoing budget constraints.
SSA	Social Security Administration	An independent agency of the federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits. The SSA issues regulations for the RSDI and SSI programs as well as Medicare and Medicaid, under the Social Security Act.
SSI	Supplemental Security Income	SSI is a program administered under Title XVI of the Social Security Act through the SSA. It is an assistance program based on need that guarantees a minimum level of income for aged, blind, and disabled persons. SSI recipients have not contributed enough to the Social Security system to be able to receive benefits on their own wage accounts.
SSDI	Supplemental Security Disability Income	A system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.
	State Plan	The State Plan is the officially recognized statement describing the nature and scope of Michigan's Medicaid program.

Acronym		Definition
SUA	State Unit on Aging	Authorized by the Older Americans Act. Each state has an office at the state level which administers the plan for service to the aged and coordinates programs for the aged with other state offices. Supports coordination Involves working with the waiver participant and others identified by the consumer, in developing a person-centered plan. Using person-centered processes, supports coordination assists in identifying and implementing support strategies to incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports.
TBI	Traumatic Brain Injury	A non-degenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairments of cognitive, physical, and psychosocial functions with an associated diminished or altered state of consciousness.
TCM	Targeted Case Management	A set of planning, coordinating and monitoring activities that assist Medicaid recipients in the target group to access needed housing, employment, medical, nutritional, social, education, and other services to promote independent living and functioning in the community.
VA	Veteran's Administration	A federal government agency that, among other things, aids veterans of the U. S. armed forces in obtaining housing. VA loans offer a guarantee to the lending institution as to repayment of the loans and result in veteran home buyers being able to obtain mortgage loans with a lower down payment.
WAP	Weatherization Assistance Program	A federally funded, low-income residential energy conservation program. The program provides free home energy conservation services to low-income Michigan homeowners and renters. Services are typically administered by local community action agencies.
	1915(b) Freedom of Choice Waiver	Section 1915(b) of the Social Security Act; provides that the Secretary of Health and Human Services (federal) may waive such requirements as statewideness, comparability of services and freedom of choice.
	1915(c) Home and Community Based Services Waiver	Section 1915(c) of the Social Security Act; provides that the Secretary of Health and Human Services (federal) may authorize a state to provide specified home and community-based services in lieu of institutional care.
	1915(b)(c) Waiver	While these are considered two separate waivers by the Secretary of Health and Human Services (federal), use of these waivers allow a state to provide long-term care services (including nontraditional community-based services) in a managed care environment or by using a limited pool of providers.

APPENDIX E – INDEX OF TABLES

APPENDIX F - ACKNOWLEDGEMENTS

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