



Michigan Elder Justice Initiative | September 2022

Barriers to Accessing Home and Community-Based Services: Recommendations for Systemic Changes

Funded by the Metro Health Foundation

By: Michael Daeshclein



Table of Contents

2 Summary

3 Introduction: Metro Health Foundation Grant

5 Stakeholder Perspectives

7 Metro Detroit Barriers are Statewide Barriers

8 History of Initiatives

15 Recommendations for Action

16 Beneficiary-Driven LTSS Funding

19 Options Counseling

32 Direct Care Workers

36 Conclusion

37 References

40 Appendices

A. MDHHS Long-Term Supports and Services Program Descriptions and MEJI Addendum

B. Long-Term Supports and Services Ecosystem

C. Web-based Options Counseling System Model

The Michigan Elder Justice Initiative acknowledges Jerry Stevens' vital work as the original Project Coordinator for the Metro Health Foundation grant. Jerry's data collection and analyses were essential to the development of this paper.

Summary

This paper describes work funded by the Metro Health Foundation to analyze barriers to accessing home and community-based services in the Detroit metropolitan area. Overcoming the barriers will be crucial to meeting the needs of long-term care consumers both in Metro Detroit and across the state. Also, the barriers are not new. The state has launched several initiatives over more than two decades to expand access to home and community-based long-term supports and services (LTSS). While these efforts achieved some success, they failed to address the fundamental weaknesses in long-term services and supports. Further, the tragic impact of the COVID-19 pandemic in nursing homes and the exacerbation of existing barriers to obtaining home and community-based services during the pandemic highlighted the urgency of achieving the systemic transformation of long-term supports and services that Michigan needs.

With federal funding through the American Rescue Plan Act (ARPA), the state now has an unprecedented opportunity to overcome longstanding barriers and transform the LTSS to better meet individuals' needs. The State's plan for utilizing ARPA funds represents a time-limited opportunity to address foundational features of an effective long-term supports and services system: flexible funding, options counseling, and

developing a strong direct care workforce. For each of these three features, the paper describes opportunities and offers specific recommendations. The paper includes an extensive discussion of options counseling because it is critical to ensuring beneficiaries receive the services that most effectively respond to their priorities, choices, and needs. An options counseling system could also inform state priorities for spending and program development, making both more responsive to the evolving choices and needs of the LTSS populations. The paper includes data from efforts to obtain basic information from current options counseling providers, and the data show unacceptable limitations that could be addressed through adequate staffing, systemic training, technology, and reporting, provided all are part of a comprehensive plan for systemic change.

While ARPA funding provides great opportunities, and the COVID pandemic amplifies the call for action, other initiatives – such as a growing consensus about the direct care workforce issues – create a demand for action by policymakers and programs. The ARPA funds can be an effective catalyst if used to advance a comprehensive plan for achieving the long-term supports and services system that Michigan's citizens need.

Introduction: Metro Health Foundation Grant

This work was funded by a grant from the Metro Health Foundation of Detroit to the Michigan Elder Justice Initiative for the purpose of identifying barriers to accessing home and community-based services (HCBS) in the metropolitan Detroit area. (See Appendix A for a description of home and community-based programs and services). While the paper's initial focus was on Wayne, Oakland, and Macomb Counties, the research revealed that the obstacles encountered in the Detroit area are also systemic and statewide. Many of these challenges have been viewed as critical for years, but the COVID-19 pandemic exacerbated the barriers and exposed the vulnerability of older adults and individuals with disabilities.

The need to address these barriers has never been stronger, and this moment provides unique opportunities to engage stakeholders, especially individuals and families who rely on long-term services and supports; build support among policy makers; and make lasting, systemic

changes to Michigan's long-term supports and services. This need for systemic change occurs at a time when the federal government is offering additional Medicaid funding through the American Rescue Plan Act (ARPA) specifically for expanding and enhancing HCBS.¹





Our goal:

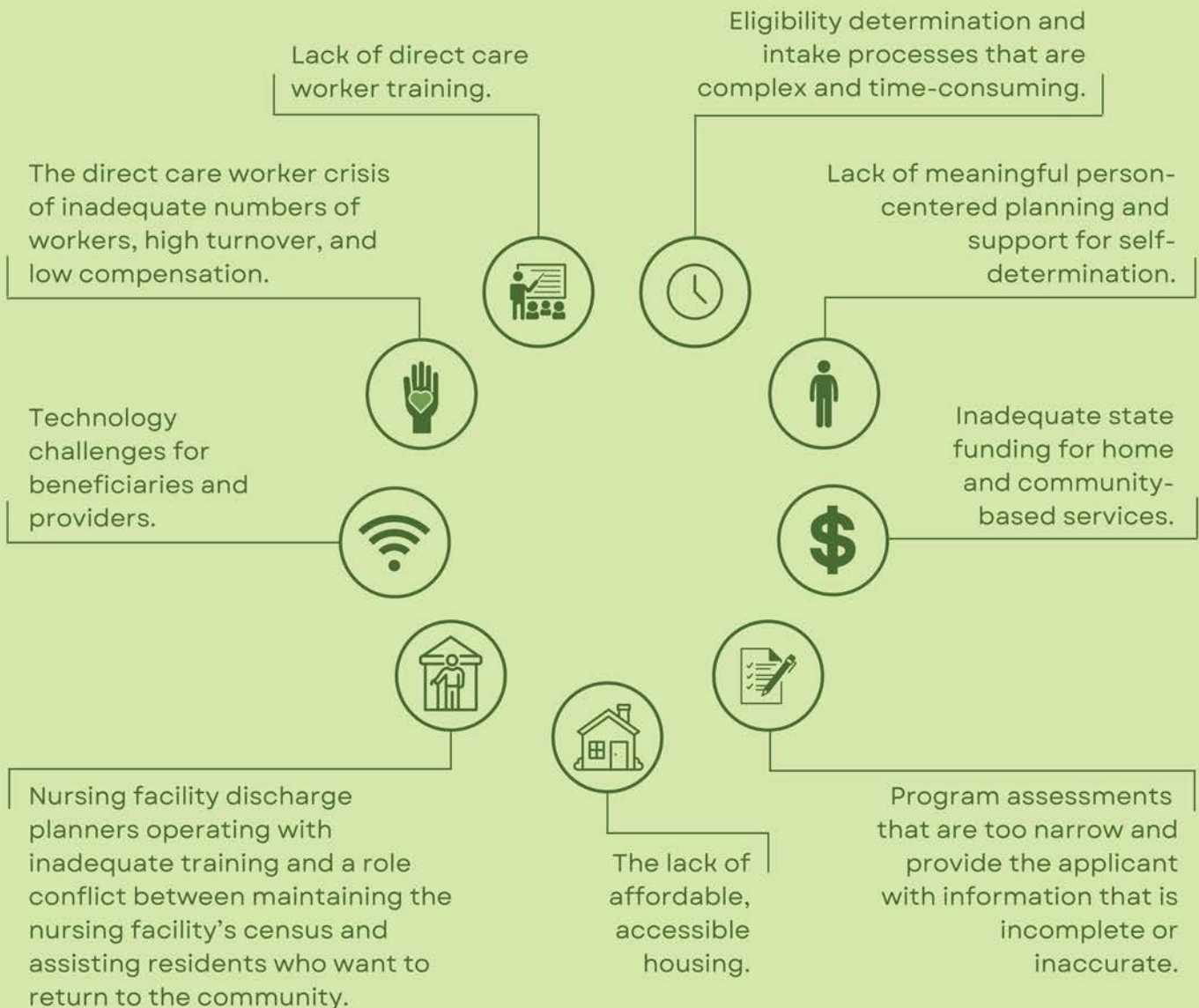
An integrated *system* of long-term supports and services that is:

- 1 Widely known and easily accessed by Michigan's citizens.
- 2 Responsive to individuals' priorities and choices.
- 3 Committed to fully informed decision-making and person-centered services.
- 4 Capable of honoring choices so that everyone who wants to receive services in their home can get what they need to do that.
- 5 Funded through flexible state spending driven by aggregate data on beneficiary choices, experiences, and outcomes.
- 6 Free of health disparities.
- 7 Consistently achieving optimal health outcomes and assuring beneficiaries a meaningful quality of life.

Stakeholder Perspectives

To learn about the barriers from different perspectives, MEJI conducted forty (40) structured interviews with beneficiaries (2), direct care workers (4), individuals representing advocacy organizations (8), Disability Network organizations (4), the Long-Term Care Ombudsman Program (5), a Community Transition Services provider (1), MI Choice waiver agencies (11), PACE (Program for All-inclusive Care of the Elderly) organizations (2), and employees of the Michigan Department of Health and Human Services (MDHHS) (3).

The most common issues cited were:



Various stakeholders also cited issues specific to their roles, such as:



The lack of awareness of home care options by hospital discharge planners, physicians, and the public.



Inadequate transportation options.



Public guardians resisting their wards' transition from nursing facilities to the community.



The lack of cooperation between Community Mental Health agencies and HCBS programs.



The need for MDHHS to manage the contracts of agencies administering HCBS programs to ensure consistency and high quality.



The need for stronger leadership by the Michigan Department of Health and Human Services (MDHHS) for redirecting funding from nursing facilities to home and community-based services.

MEJI also collected data on what individuals might find when seeking basic information about home care. These data are discussed in the Options Counseling section of this paper.



Metro Detroit Barriers are Statewide Barriers

The stakeholder interviews and data collection showed that the major barriers found in Metro Detroit are largely the same as the barriers identified by others throughout the state. There are likely differences because metropolitan Detroit has many unique characteristics, such as population size and the racial and ethnic composition of the population. At the same time, barriers in other parts of the state, such as the rural northern Michigan and Upper Peninsula, have common contributing factors, such as the shortage of direct care workers, transportation, and affordable housing. Addressing those factors will require changes in state policy and operations for long-term services and supports (LTSS).

One example of a Metro Detroit difference is the time a person might be on the waiting list for MI Choice services. The original allocation of funding across the state's fourteen MI Choice service areas did not correspond to demographics, such as the number of Medicaid beneficiaries in each service area. The disparity in funding became clear when the program implemented a reliable, web-based waiting list and the difference in wait times varied from 2-3 months in some service areas to 12 months or more in other areas. In 2014, MDHHS implemented an algorithm for allocating funding that has gradually equalized the wait list time across the state. Three of the MI Choice service areas cover the southeast Michigan counties of Wayne, Oakland, Macomb, Livingston, Monroe, St. Clair, and Washtenaw. In 2014, the SE Michigan counties had an average wait time that was 67 days longer than the statewide average (194 vs. 127 days). In 2021, that difference was only two days.² This is an example of a long-standing difference in Metro Detroit's access to HCBS that was effectively addressed by MDHHS.

Reducing disparities:

Wait time for MI Choice applicants in SE Michigan compared to the statewide average:

67 days longer in 2014

2 days longer in 2021



History of Initiatives

Many of the barriers to expanding HCBS have been known for at least two decades and multiple initiatives have attempted to address them. This section briefly describes some of these efforts. The purpose is to illustrate the long-standing awareness of the need for change and the difficulty in addressing large, systemic challenges.



2001: *Eager v. Engler*³

In 2001, the MI Choice program was closed to new applicants, and funding was significantly reduced. The following year, The Michigan Poverty Law Program (which later launched the Michigan Elder Justice Initiative) and Michigan Protection and Advocacy Service (now Disability Rights Michigan) represented five organizations and seven individual consumers with significant disabilities who sought to remain in or return to their homes. The plaintiffs sued the state in federal court pursuant to the Medicaid Act and the Americans with Disabilities Act. In 2004, the parties in the *Eager, et al. v. Engler* lawsuit signed a Stipulation of Settlement that included the admission of all the remaining named plaintiffs to the MI Choice program, the reopening of the program to new applicants, an additional allocation of \$25 million to the \$100 million MI Choice budget, the implementation of a single screening tool for all applicants to MI Choice and individuals seeking Medicaid-funded nursing facility care, the dissemination by the state of public information and training about home and community-based services, the creation of waiting lists for the MI Choice program, an effort to obtain funding for nursing facility transitions, and the creation of the Governor's Long Term Care Task Force.

MDHHS implemented a waiting list that provides credible documentation of the number of referrals. In addition, in 2004, Governor Granholm created the Medicaid Long-Term Care Task Force, described below. Nursing facility transitions increased with the implementation of supportive policy in 2005, and the Centers for Medicare and Medicaid Services (CMS) Money Follows the Person Grant, which began in 2007. Over time, as the MI Choice program demonstrated the effectiveness of transition services and the waiting list demonstrated the increasing demand for services, the Michigan legislature provided annual appropriation increases for the program. The current MI Choice appropriation is over \$437 million.

2003: Aging and Disability Resources Centers

In 2003, the federal Administration on Aging (now a part of the Administration on Community Living) awarded planning grants for states to develop a system of Aging and Disability Resource Centers (ADRCs), which were to provide individuals with complete information on LTSS and other resources. The Michigan Office of Service to the Aging initiated a planning process that included Area Agencies on Aging, Centers for Independent Living (now Disability Network organizations), and other community partners. Communities covering nearly all of Michigan developed plans with the expectation of federal funding to support implementation. When the Administration on Aging did not fund implementation efforts, the planning ended and ADRCs were not realized.⁵

2004: Medicaid Long-Term Care Task Force

In 2004, as a result of the *Eager v. Engler* settlement agreement, the Granholm Administration established the Michigan Medicaid Long-Term Care Task Force, which included a widely diverse membership. The resulting report⁶ represented a common vision and recommendations for person-centered planning, Money Follows the Person funding, a single point of entry program, a greater array of services and supports, prevention activities, and workgroups to address the long-term care workforce and LTSS financing. Since that report, progress has been made on some of the recommendations: person-centered planning has been included in Medicaid program policy;⁷ a Single Point of Entry regional pilot was conducted for three years and ended when the Michigan legislature stopped appropriating funds for the program; the MI Choice budget has increased; the PACE (Program for All-Inclusive Care for the Elderly) has expanded to 13 provider organizations; and the MI Health Link integrated care demonstration began in 2015. However, the state has not adopted the Money Follows the Person principle in LTSS funding, which would ensure that funding moves from setting to setting and service to service as a person selects different long-term options. In addition, the Single Point of Entry pilot program has not been replaced and little has been done to address the workforce problems.





2015: HCBS Access Barriers, Continuous Quality Improvement Initiative

In 2015, the Office of Aging and Adult Services (now reorganized into the MDHHS Behavioral and Physical Health and Aging Services Administration) was designated the lead agency for an inter-agency initiative to address barriers to accessing HCBS. The workgroup analyzed the many access routes and relationships between the various LTSS programs and the daunting difficulty in navigating them. (See Appendix B for the workgroup's Long-Term Supports and Services Ecosystem diagram.) Continuous Quality Improvement design teams were formed to develop recommendations for specific process improvements. Design team efforts led to improved access to Non-Emergency Medical Transportation, significant changes in the Nursing Facility Level of Care Determination process, the development of an electronic Pre-Admission Screening and Resident Review process for nursing facility admissions, development and federal approval of a 1915(i) State Plan amendment for Community Transition Services, and more.

This work continues today with design teams for independent options counseling, MI Choice, nursing facilities, Diversity, Equity and Inclusion, and other topics. This initiative has had sustained success on a variety of relatively narrow, program-specific issues. However, it has not led to changes to the larger, systemic barriers to accessing services.

Direct Care Workforce

Long before the COVID-19 pandemic, nursing facilities, other residential settings, and home care agencies were unable to attract and maintain adequate workforces. Michigan has at least five diverse groups specifically working on workforce issues. These include:

- **Direct Care Worker Advisory Committee**, MDHHS-led stakeholder group.
- **IMPART Alliance**, working on advancing the status and professionalism of direct care workers.
- **Essential Jobs, Essential Care**, a multi-state initiative led by PHI, a national direct care worker advocacy organization.
- **Incompass Michigan**, a statewide provider network partnering with the IMPART Alliance.
- **Michigan Direct Care Workforce Wage Coalition**, a coalition of advocacy and provider associations advocating for wage increases in behavioral health services.⁸

There are abundant and diverse members, viable ideas, and a commitment to change. The groups have coordinated their efforts and produced proposals for direct care worker competencies, training, and credentialing, as well as continuing their advocacy with legislators and others.⁹ The pandemic conditions revealed how direct care positions are extremely demanding, risky, and undervalued, and how the barriers to building an adequate workforce are persistent and resistant to change. The \$2.00-\$2.35/hour wage increases provided by the state legislature during the federal Public Health Emergency are important, but far from sufficient. Much more needs to be done to create lasting improvements to wages and benefits, training, and career paths, working conditions, and, most fundamentally, the public perceptions of the value of the work.



Impact of Lack of Progress

This summary of initiatives and efforts underscores the long-standing recognition of the inadequacy of Michigan's LTSS and its history of analytical work and planning to address systemic barriers. However, Michigan's failure to overcome the barriers has contributed to an imbalance in how MDHHS spends LTSS funding between HCBS and institutional care.

A recent Mathematica report on LTSS balance and rebalancing efforts¹⁰ describes whether states achieve an equal balance as a standard in discussing national and state progress. However, it is arbitrary and misleading to treat measures above 50% as successful and those below 50% as unsuccessful. The most important measure is the extent to which people receive the services they choose and need, which is not measured.



AARP LTSS Scorecard Ranking

2020 HCBS spending as a % of all LTSS:

#1 New Mexico	73.5%
#29 Michigan	31.5%

The Options Counseling section of this paper includes recommendations for this type of data collection. AARP publishes an LTSS Scorecard every two years which provides state data on a variety of measures.¹¹ The 2020 report (using 2018-2019 data) shows that, on HCBS spending as a percent of all LTSS spending, Michigan ranked 29th, spending only 31.5% on HCBS. New Mexico had the highest percentage of LTSS spending on HCBS at 73.5%. Prior reports show similar numbers; the 2018 AARP Scorecard reported data for 2016 (Michigan ranked 29th, spending 31% on HCBS) and 2011 (Michigan ranked 35, spending 23% on HCBS). Michigan does rank 19th in the percentage of LTSS users receiving HCBS (62%), but we do not know how that compares to the percentage of Michigan beneficiaries who *want* HCBS. Michigan's overall AARP ranking is 30th, which is one indicator that there is considerable room for improvement.

The barriers to accessing HCBS were known for years prior to the COVID-19 pandemic. The pandemic exacerbated those barriers and its impact on older adults and people with disabilities provided far too much evidence of the vulnerability of the LTSS population. As of April 9, 2022, the COVID deaths of individuals over age 65 were 74% of all COVID deaths nationally and 76% in Michigan.¹²

The pandemic also revealed the vulnerability of nursing facility residents. Nursing facility residents make up 19% of COVID deaths as of October 2021, despite the fact that they are only 0.5% of the U.S. population, and had 1.6% of COVID cases.¹³ Nursing facilities were high-risk environments, not simply because of the health status of the residents and congregate living conditions of close proximity and hands-on care, but also because nursing facilities have a history of poor infection control. In 2020, 42% of nursing facilities received infection control citations.¹⁴ If the state had an effective LTSS system in which HCBS were more widely available to all who sought it, it is indisputable that more LTSS consumers would have been in their homes where they would have been less vulnerable to COVID-19.

Unprecedented Opportunities

As the COVID-19 pandemic amplified the need for LTSS improvements, it also triggered greater federal support for HCBS. The American Rescue Plan Act (ARPA)¹⁵ provides states with additional Medicaid funding equal to the amount each state spent on Medicaid HCBS from April 2021 through March 2022. The ARPA gives states broad latitude in how to use the funds.¹⁶ However, funds are only available until March 31, 2025, which is a short timeline for major initiatives in state government.

Michigan's ARPA Home and Community-Based Services Spending Plan¹⁷ was submitted on July 12, 2021, and received partial approval by CMS on September 30, 2021. The plan's Phase 1 investment in HCBS included an additional 1,000 slots for the MI Choice program beginning October 1, 2021. The plans for Phases 2 and 3 "...require additional development and discussions with the Michigan stakeholder community, MDHHS executive leadership, and the state legislature."

Finalization of the Phase 2 investments was to be reported to CMS in the October 1, 2021, quarterly spending plan. The most recent quarterly spending plan does not mention additional work on the finalization of Phase 2.¹⁸ The quarterly report did update the amount of extra federal funding to \$273,755,400.



The plan lists potential investments for Phases 2 and 3 that could impact the barriers to accessing HCBS. These include conducting an HCBS awareness campaign, providing options counseling prior to a patient's discharge from a hospital, expanding the use of technology, and multiple initiatives to strengthen and expand the LTSS workforce through compensation, incentives, training, and other strategies.

A grant from the Michigan Health Endowment Fund provides MDHHS an opportunity to investigate health disparities as a potential barrier to accessing HCBS. At a time when health inequity is increasingly recognized as a systemic healthcare problem, the pandemic's impact fell disproportionately on people of color.¹⁹ The challenge of eliminating health disparities adds to the

urgency of achieving systemic reforms and provides a key organizing principle for change initiatives. This grant will focus on four counties: Wayne, Kalamazoo, Grand Traverse, and Chippewa. The grant includes analyses of current program statistics to identify health inequities in those counties and statewide. It will also examine health inequities with and between the following programs and services: MI Choice, MI Health Link, Home Help, Home Health, and PACE. Additionally, the grant will include community researchers to gather information from individuals within each of the counties about their experience in accessing and using services. The grant is expected to provide information important to the development of systemic changes in HCBS.

Summary

The many needs for systemic change are more evident than ever and the opportunities to address the needs are unprecedented. An analysis of MDHHS data may reveal regional differences, whether in metro Detroit or the Upper Peninsula, that have implications for reform strategies, but the statewide systemic changes needed will be the foundation for regional adaptations. This moment represents a convergence of urgent, growing needs, collaborative efforts, and rare funding opportunities. So, the question is:

if not now, when?

Recommendations for Action

The introduction of this paper described a goal of having an integrated LTSS system that includes the following features:

- 1 Widely known and understood by Michigan's citizens.**
- 2 Responsive to individual's life priorities and choices.**
- 3 Supports fully informed decision-making and person-centered services.**
- 4 Has the capacity to honor choices, even when that requires innovative options.**
- 5 Funded through flexible state spending driven by aggregate data on beneficiary choices, experiences, and outcomes.**
- 6 Free of health disparities.**
- 7 Results in optimal health outcomes and a meaningful quality of life.**

The first three features would be addressed primarily through options counseling services, features four and five are largely dependent on funding and related policy choices, and features six and seven depend on reliable, statewide data collection and reporting. These features are discussed in the following sections and include recommendations for action. It is important to note that the recommendations are offered as input to a larger development process led by MDHHS with stakeholders as active members.



Beneficiary-Driven LTSS Funding

The History of Initiatives section cited Michigan’s lack of success in expanding HCBS funding as a percent of all LTSS funding. In addition to the balance between nursing facility and HCBS funding, Michigan’s spending on LTSS is low in relation to other states. The January 2021 CMS Medicaid LTSS Expenditure Report ²⁰ ranks Michigan 38th among states in the amount of LTSS funding per state resident. In 2018, Michigan spent \$395 per state resident, compared to Utah at the low end (\$238), Minnesota at the high end (\$1,103), and the national average (\$608). **However one looks at it, Michigan does not spend enough on HCBS.** That said, this section focuses on how the funding is spent, rather than the amount. For Michigan to spend its LTSS funding effectively, MEJI proposes three essential principles:



1 Funding decisions must respond to individuals’ life priorities and choices about services.

This is equally true at the individual level when service plans are developed, and at the aggregate level when MDHHS budget decisions are made. The term “person-centered planning” can be found throughout Michigan’s Medicaid policy, LTSS program descriptions, provider contracts, and many other documents. The term only becomes meaningful when this principle is operating. The sections on Options Counseling and Data Collection and Reporting describe the source of the necessary data.

2 Funding must align with individuals’ needs.

Individuals with extensive or complex needs will, in most cases, require services that cost more. Beneficiary acuity should be the primary factor in determining provider rates.

3 The total LTSS budget must have the flexibility to employ CMS’s “Money Follows the Person” strategy.

Changes in the LTSS population’s choices and needs must drive state budget decisions. The funding must also have the flexibility to support innovation in technology and new service models that can more effectively respond to choices or more efficiently use resources.

One of the greatest barriers to MDHHS’s employment of these principles is its method of funding nursing facilities. Nursing facilities receive the largest share, approximately two-thirds of the approximately \$3.3 billion LTSS annual spending.²¹ A recent survey²² found that 88% of adults would prefer to receive long-term care services in their home or the home of a loved one, 10% preferred a senior community and 2% preferred a nursing home. In another study, AARP found that 77% of adults over fifty want to age in place.²³ As noted earlier, Michigan’s HCBS funding for older individuals and adults with disabilities as a percent of all LTSS funding is in the bottom quartile compared to other states, and 62% of LTSS beneficiaries are receiving HCBS, which does not correspond to preferences expressed by those likely to need LTSS.

LTSS Preferences of Surveyed Adults



Michigan’s method of funding nursing facilities is also a barrier to the second principle, funding based upon resident needs. A 2019, Performance Audit Report by the Michigan Office of the Auditor General: “*Administration of Medicaid Payments to Nursing Facilities for Long-Term Care. Michigan Department of Health and Human Services.*”²⁴ The report had one material (a serious matter indicating inadequate internal controls) finding: “MDHHS’s Medicaid LTC cost reimbursement methodology is complicated, labor-intensive, ineffective and inefficient.” MDHHS’s preliminary response was that it agreed. The audit included research on other LTC reimbursement methodologies and found that: “...Michigan is 1 of only 2 states that utilize an annually adjusted, facility-specific Medicaid cost reimbursement methodology that is based on actual allowable costs. *The methodology does not consider the difference between the level of care provided and the level of nursing care needed for each patient.*” (p. 10, emphasis added) The audit also cites a June 2015 MDHHS position paper that listed the benefits of an acuity-based reimbursement system and MDHHS’s current use of an acuity-based methodology for Medicaid-certified State veterans’ homes.

“ MDHHS’s Medicaid LTC cost reimbursement methodology is complicated, labor intensive, ineffective and inefficient”
- MI Office of Auditor General

To summarize, the Office of the Auditor General describes MDHHS’s methodology as ineffective and inefficient and MDHHS agreed (2019), MDHHS recognizes the benefits of an acuity-based system (2015) and has used this methodology in Medicaid-certified State veteran homes (since 2019). Therefore, it is clear that MDHHS must implement an acuity-based system for all nursing facilities if it is going to use tax dollars responsibly and use Medicaid funds to most efficiently and effectively meet the needs of beneficiaries.

Regarding the third principle, having the budget flexibility to support Money Follows the Person principles, the Michigan legislature authorizes MDHHS spending by program, so moving funds to follow people takes legislative action. In Michigan, money does not follow the person. Instead, people follow the money, that is, they go where services are available. It will take a shared commitment by the administration and the legislature to remove this barrier to using state funds for the service of beneficiaries instead of providers.

Opportunities

In 2019, CMS replaced the Medicare method for assessing acuity in the Medicare payment system, Rugs Utilization Scores, with the Patient-Driven Payment Model (PDPM). The PDPM produces a more precise measure of acuity and resident need. Michigan's nursing facilities began collecting PDPM data in 2021²⁵ so it is available to deploy in a new, acuity-based reimbursement methodology.

Recommendations

- 1** MDHHS is currently analyzing options for developing an acuity-based reimbursement methodology. This will be a major change for the nursing facility industry in Michigan, especially for facilities currently receiving high rates and serving a relatively low acuity population. Therefore, the transition needs to be thoroughly planned with stakeholder input. This will benefit the nursing facilities that serve residents with higher acuity and the LTSS beneficiaries that use them, so the challenges of the transition should not delay implementation.
- 2** There is considerable evidence that nursing facilities that rely heavily on Medicaid funding, as opposed to the higher reimbursement from Medicare and private pay residents, disproportionately serve people of color and do not perform as well on measures of quality of care and quality of life as nursing facilities that have a better mix of funding sources. The development of a new reimbursement methodology should include factors that reduce these significant health disparities.
- 3** The funding recommendations would improve the flexibility and responsiveness of Medicaid LTSS spending. However, to achieve beneficiary-driven spending, MDHHS must be informed by the priorities and service choices of people seeking LTSS, the extent to which they have been met through participation in LTSS, and where LTSS failed to meet their needs. The options counseling recommendations describe a source for this information.

Options Counseling

“Options counseling” is a term that encompasses Information and Assistance, a core function of Area Agencies on Aging; Information and Referral, a core function of Disability Network organizations (also known as Centers for Independent Living); and person-centered planning, which is the standard care planning process for all Medicaid HCBS, including the MI Choice waiver, the Home Help program, the PACE (Program of All-Inclusive Care for the Elderly) program, and the MI Health Link HCBS waiver program. Person-centered planning provides the principles and methods that guide effective options counseling. Person-centered planning also relies on thorough options counseling as an essential part of the planning process. As used in this paper, options counseling is a process central to all HCBS programs.

In addition, the term “Aging and Disability Resource Centers” describes an organizational model for providing options counseling that is more representative of the LTSS population in its inclusion of individuals with disabilities. “No Wrong Door” is a term that captures an essential feature of options counseling where a person would receive complete information regardless of the person's first point of contact within LTSS.

The History of Initiatives section of this paper describes multiple initiatives that identified barriers to accessing LTSS and attempts to address them. The 2015 Office of Services to the Aging initiative to address access barriers began with a thorough mapping of the many access paths to LTSS. (See Appendix B for the Long-Term Supports and Services Ecosystem diagram.) It showed multiple funding streams and programs with their own access points and eligibility criteria, presenting potential users with a confusing bureaucratic maze. Anyone with urgent needs, such as during a hospital discharge, would not learn about all their options. Even with time to search, individuals would likely find only a partial picture of their options, depending on where they started. The diagram describes a dysfunctional assembly of programs where frustration, failure, and poor outcomes are far too common. Further, if the diagram were updated, it would be more complex and hostile to people seeking LTSS.



Options counseling is the foundation of an efficient and effective LTSS system as described in the Introduction of this paper. MEJI proposes the following features for the development of an options counseling service. As noted earlier, this model and recommendations are offered as input to a larger development process that would be led by MDHHS with stakeholders as active members.



The options counseling provider would be recognized as the one source of information and assistance by anyone, regardless of their current involvement in LTSS, including people who anticipate needing assistance and people not enrolled in Medicaid.



The options counseling provider would have well-trained staff able to provide information on all relevant programs; learn enough about callers to understand their priorities, choices, and needs; and provide either more intensive person-centered planning or assist the callers in accessing other providers for further assistance. MDHHS would be responsible for ongoing, competency-based training.



The options counseling provider would have sufficient staff capacity to answer calls with a minimum wait time, be available during hours beyond standard business hours, and respond quickly to urgent needs.



The options counseling process would be assisted by a web-based system that facilitates effective responses to callers, maintains current information on state and community options; and collects information on demographics, priorities, choices, services accessed, unmet needs, and care transitions. This information would be used by the state to make program development and funding decisions as well as provide information to the public. (This web-based system is described in more detail in Appendix C.)



The system would also capture information on the options counseling provider's performance in relation to specific performance standards, such as call wait time, thorough and responsive information on options, caller outcomes and satisfaction, and other measures. This system would be operated by MDHHS for monitoring the quality of performance by options counseling providers, assessing training needs, and supporting continuous quality improvement efforts.



The options counseling services would be conflict-free, that is, the organization providing options counseling could not financially benefit from the choices made by service users. This would be achieved most reliably by options counseling providers that had no role in service provision. Whether Michigan chooses this approach or an approach that uses organizational firewalls (i.e., programs organized to ensure a high level of independent operations) the options counseling performance standards, training, data collection, and reporting could provide the transparency necessary to give users confidence in the services provided.



Current Options Counseling Services

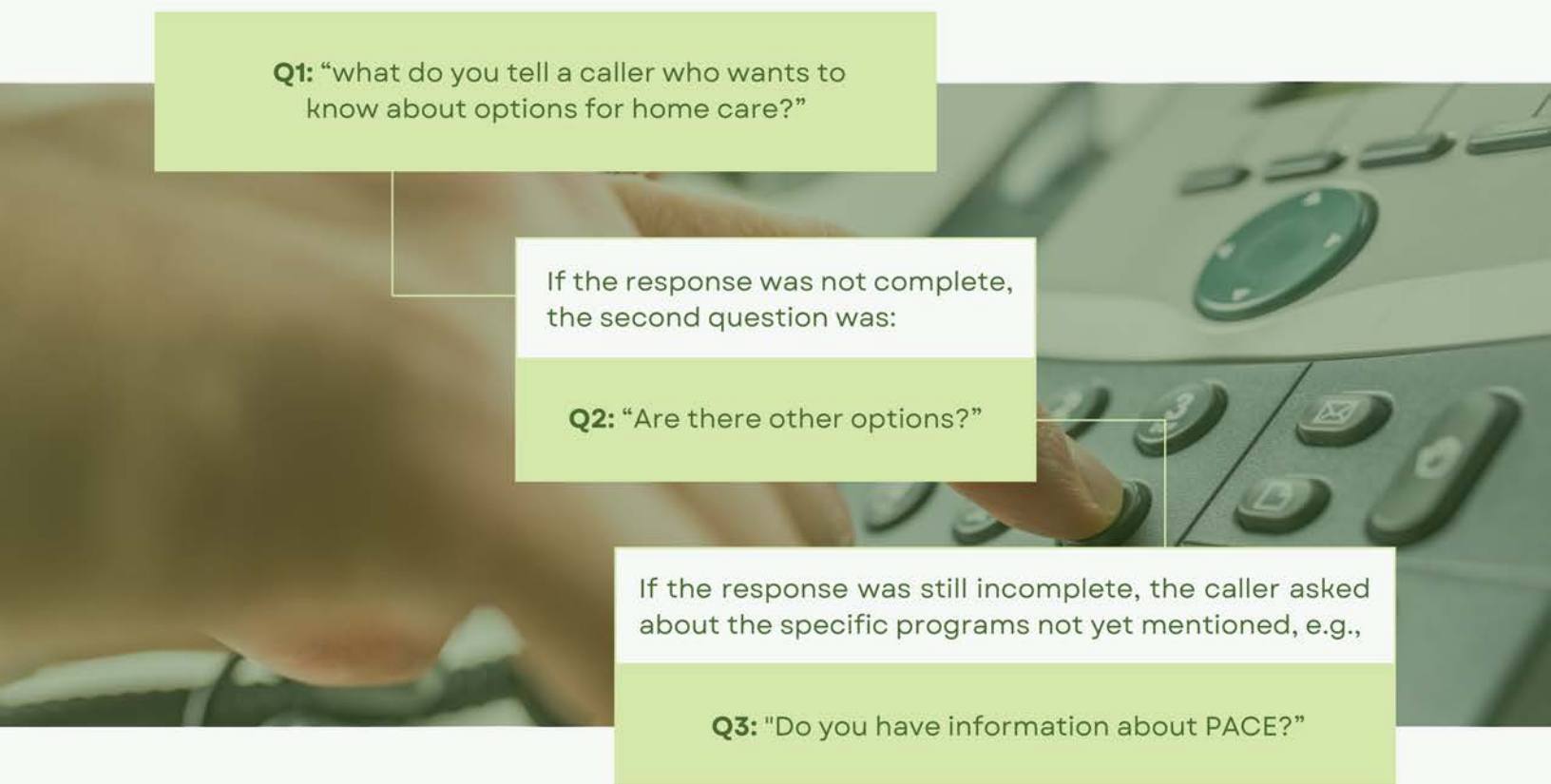
In 2021, MEJI was compiling information for a nursing facility resident fact sheet that would include contact information for HCBS, specifically information available via phone for people who do not use the internet. To ensure the accuracy of the fact sheet, MEJI contacted local organizations to ask what information they provided to callers seeking options for home care services. Michigan has 16 Area Agencies on Aging (AAAs) that serve the entire state. Fourteen of the AAAs are also waiver agencies that administer the MI Choice waiver program, along with six MI Choice waiver agencies that are not AAAs. The Area Agencies on Aging Association of Michigan describes the AAAs as “...experts on all aspects of aging, assisting older adults and caregivers with information and resources.”²⁶ Because of this central role for older adults (and adults with physical disabilities, as MI Choice waiver agents), the AAAs were the focus of the data collection described in the section.

The purpose of the data collection was to learn about the responsiveness and the completeness of options counseling. Again, options counseling is used as a broad term inclusive of information and assistance and person-centered planning. The AAA employees answering the calls had a variety of titles and might be the first step in a more extensive process. Responsiveness was defined as the number of business days between the MEJI calls and the agency’s response. The calls occurred during October and November 2021, when the AAAs were operating with COVID-19 mitigation procedures, which meant that most of the employees were working from home. This often meant that callers could only leave a message that would be relayed to the options counseling staff. MEJI called each AAA up to three times, with the calls 4-5 days apart.

Completeness was defined as whether the key programs were cited, and contact information was available. The options counselors typically provided additional information about each program and asked questions to better understand the needs of the person discussed. The options counselors were asked to consider an example of a nursing facility resident wanting to return to the community who has a need for ongoing personal care and had or was likely eligible for Medicaid. A complete response consisted of citing the following programs:

- | | |
|--|--|
| 1 Care Management
(Older Americans Act services) | 4 Community Transition Services
(State Plan Service) |
| 2 MI Choice waiver | 5 PACE, if available in the service area |
| 3 Home Help Program | 6 MI Health Link, if available in the
service area |

This was not a “secret shopper” call; the MEJI caller identified himself and his employer and said he wanted to know what information a caller would receive regarding local home care options. Each call included the same three questions:



Q1: “what do you tell a caller who wants to know about options for home care?”

If the response was not complete, the second question was:

Q2: “Are there other options?”

If the response was still incomplete, the caller asked about the specific programs not yet mentioned, e.g.,

Q3: “Do you have information about PACE?”

In question three, the caller also asked about Community Mental Health Services, Disability Network organizations (Centers for Independent Living), and Brain Injury Services, if they had not been mentioned earlier.

Limitations of the Data

The data only describe one encounter with an agency, typically one discussion. That discussion may or may not be fully representative of that organization's performance. Many organizations have more than one employee responding to the calls and the employees had a wide range of experience. The tables present one snapshot of information and assistance for each agency, which is one component of options counseling. Therefore, the AAAs are not identified. **The value of the data is not in assessing each AAA's performance; it is in presenting an overall picture of the variability and limitations across the state's AAAs.**

Table 1. Responsiveness To Requests for Information

Table 1 shows the number of business days from the MEJI call to the AAA's return call and the number of calls made to each AAA. The AAAs are arranged from the fewest to the most business days and calls.

Table 2. Completeness of Information on Home Care Options

Table 2 shows which of the programs were cited in response to each of the three questions. The AAAs are arranged from the most complete to the least complete responses. The order of AAAs in the completeness table is different from the order of AAAs in the responsiveness table.



Table 1: Area Agencies on Aging Responsiveness to Requests for Information

There were 4 or 5 business days between calls to an agency.
For the first two calls, the message left was:

"I am looking for information on home care options."

For the third call, the message was the same, plus:

"This is my third call."

The Area Agencies on Aging are arranged from the fewest days to the most days until they called back. The letters used in the third row do not correspond to the region numbers of the agencies. Also, an AAA's letter in Table 1 is not the same as its letter in Table 2.

Business days until agency called back	First call	First call	First call	First call	First call	1	1	1	2	2	10	11	11	13	14	17
Number of calls	1	1	1	1	1	1	1	1	1	1	2	2	3	3	3	3
Area Agencies on Aging	a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.



Table 2: AAAs Completeness of Information on Home Care Options

Each cell shows which question elicited mention of the program or service.

Q1: What are the options for home care?

Q2: Are there any other options?

Q3: Do you have information on (cite each program not listed in response to Q1 and Q2)

Zero (0) indicates no information was provided.

Area Agencies on Aging	Complete Response to Question 1						Additional Services Discussed in Question 3		
	Care Management	MI Choice waiver	Home Help Program	Community Transition Services	PACE (where available)	MI Health Link (where available)	Community Mental Health	Disability Network	Brain Injury Services
a.	2	1	1	3	1	1	3	3	0
b.	1	1	2	3	1	3	3	3	0
c.	3	1	3	3	1	1	3	3	0
d.	1	1	3	1	3	3	3	3	0
e.	1	1	3	3	1	3	3	3	0
f.	1	1	3	1	3	3	3	3	0
g.	1	1	3	1	3	3	3	3	0
h.	1	1	3	2	2	3	3	3	0
i.	1	1	2	3	2	3	3	3	0
j.	1	1	2	3	3	3	3	3	0
k.	1	1	2	3	3	3	3	3	0
l.	2	1	3	1	3	3	3	3	0
m.	1	3	3	1	2	3	3	3	0
n.	1	1	3	3	3	3	3	3	0
o.	2	2	1	3	2	3	3	3	0
p.	2	2	3	3	3	3	3	3	0

Discussion

Table 1. Responsiveness to Requests for Information

Ten of the AAAs called back within two days, which is reasonable under the pandemic work conditions. Six AAAs had a call-back time of ten days or more, which is unacceptable under any conditions. At five AAAs, the MEJI calls were answered by a receptionist and transferred; the other AAAs had an automated answer that asked the caller to leave a message. Some of the automated responses cited the high call volume and indicated that it may take a certain number of days to return the call. Two AAAs with that message replied in two days. One AAA said the reply would be within three days and it took over 10. Another mentioned the high call volume and asked for patience; that reply took over 10 days. Another AAA’s message cited the high call volume and said the reply would take three days; this AAA also took over 10 days. When the AAAs did call back, the callers apologized for the delay, were friendly and helpful, and took the time to answer the questions. It was clear that at least six of the AAAs did not have adequate staffing to respond within a reasonable amount of time.

Call-back time:	Completeness:
10 AAAs - within 2 days	9 of 16 AAAs cited only 3
6 AAAs - 10 days or more	program options.

Table 2. Completeness of Information on Home Care Options

Decreasing the response time would be simple, although doing so probably requires additional funding. However, increasing the completeness of the information provided is more complicated. Training, performance standards, a web-based system, and transparent performance reports will be essential to improving the completeness of information. Note that identifying programs and having contact information are the most basic components of Information and Assistance or options counseling.

The number of programs necessary for a complete response varies depending on the availability of the PACE program and the MI Health Link program in that service area. (Note: Table 2 shows a “3” for those programs not available in an AAA’s service area. The purpose is to maintain the anonymity of the AAAs.) One AAA provided 5 of the 6 options within the first two questions, and six AAAs cited four of the options. Nine of the 16 AAAs provided only three options. It is important to note that all the AAAs had information about all the programs (except Brain Injury Services), but they only provided complete information if the caller asked about specific programs in Question 3. Obviously, a caller seeking information can’t be expected to ask about specific programs the AAA fails to mention.

The data also raise questions about potential appearances of conflict of interest. All sixteen AAAs provide Older American Act-funded services, which are often called “Care Management.” Fourteen of the 16 AAAs also provide MI Choice waiver services, which is a major source of funding for those agencies. Ten of the 16 AAAs included Care Management and MI Choice in their answer to the first question, and five of these AAAs only cited the two services they provide. Contrast that with the information provided about the PACE program. PACE is an option for many individuals also eligible for MI Choice. Fourteen of the AAAs have a PACE program in their service area, but only four AAAs cited PACE in response to the first question, another four AAAs cited PACE in response to the second question (any other options?) and six of the AAAs only mentioned PACE when specifically asked about the program. Incomplete options counseling with the appearance of a conflict of interest is far from the options counseling needed by Michigan’s citizens.

The Home Help program is another example of risks associated with incomplete options counseling. The Home Help program serves over 50,000 Medicaid beneficiaries and is by far the least expensive source of personal care services. The Home Help program is available statewide through the MDHHS local offices. Therefore, Home Help might be where one would start when describing home care options, yet ten of the AAAs only mentioned Home Help when specifically asked about it in question three. MDHHS should provide the services individuals need, and do it in the most cost-effective way possible to meet their fiscal responsibilities to Michigan taxpayers. If most callers do not learn about Home Help, there could be many people not receiving the most cost-effective services that meet their needs. Further, as a State Plan service, anyone meeting the eligibility criteria can access services, whereas the other HCBS programs have additional eligibility criteria and may have waiting lists. It is possible that someone could fail to access one of the other HCBS programs and not know about Home Help, for which they might be eligible.



The Home Help program is the least expensive source of personal care services and widely available, but **ten of the AAAs only mentioned Home Help as a home care option when specifically asked about it.**

Qualitative Data

The MEJI caller also asked about what programs might meet specific needs, the training they received, and if they used a computer program to maintain the information on options. These were open-ended questions in contrast to the completeness questions that prompted all the possible responses. Consequently, some of this information may be under-reported. Also, one AAA did not respond to these questions because the person had to leave for a meeting, so the total possible is only 15. The responses are summarized below:

If a nursing home resident lost mobility and uses a wheelchair, but the resident's home has steps to each entrance and an unsafe bathroom, what program would help the person return home?

Community Transition Services, MI Choice, PACE, and MI Health Link provide home modifications, including ramps under certain conditions. Four AAAs cited Community Transition Services, six cited MI Choice, and no AAA cited the MI Health Link waiver program. Eleven AAAs described specific community organizations that provide low-cost or free ramps; of these, three AAAs only cited community organizations. There was considerable valuable knowledge about community programs, however, the Medicaid programs were cited by only six AAAs and none cited all the Medicaid possibilities.

What programs would one call if a person needed 24-hour care?

MI Choice and the MI Health Link waiver program do not prohibit 24-hour per-day care plans, and the amount of care should be based on the assessment. While the direct care worker shortage can be a constraint, that should be a consideration after the assessment determines the optimal level of personal care services. It is rare for a beneficiary to receive that level of service, but it is possible. Five of the AAAs cited MI Choice, based upon the assessment. No other programs were cited. Further, eight AAA said they do not provide 24-hour care and two said that no one does. Three said that someone with that level of need would be served in a nursing facility. There are many people who have extensive care needs and live successfully in the community, some with little or no informal supports. A common barrier is the lack of staffing but, regardless of the challenges in arranging 24-hour services, everyone should know it is possible within Medicaid HCBS. **Also, no one with extensive needs should only have nursing facility care as an option.**

What programs would a family call if it had a member with dementia who needed lots of supervision?

A person with dementia might qualify for Home Help, MI Choice, PACE, or MI Health Link waiver services. Nine AAAs cited MI Choice and three cited PACE; none cited Home Help or MI Health Link. Eight AAAs also cited caregiver training provided by their agency.

What training do you receive to do this job?

Nine AAAs specifically cited co-workers as the source of training, but only one AAA only cited co-workers. Most AAAs cited multiple sources, such as other agencies, self-study and problem-solving, and supervisors. Only two mention curricula or manuals, suggesting the training is unique to each AAA. Four AAAs cited AIRS, a national company that provides training and certification in Information and Referral Services. While many training sources were identified, this is far from the competency-based, statewide, ongoing training MEJI recommends. Further, the Completeness data suggests that the training currently provided is inadequate.

Do you use a computer program to assist you and manage all the information?

Only four AAAs reported that they do not use computer programs and rely on paper documents for information. Eleven AAAs reported that they use computer programs. Two mentioned Wellsky, a case management software available for purchase. This was one of the last questions in the calls and did not result in much discussion. There does appear to be considerable potential for strengthening the services with more extensive use of technology.

Summary

The AAA representatives were friendly, patient, and intent on being helpful. They demonstrated professionalism and motivation. **The shortcomings in the responsiveness and completeness were not the failure of individual staff members; they were the product of the system the staff members work in.** At least six AAAs do not have sufficient staffing to respond to calls in a reasonable amount of time. Only one AAA came close to MEJI's standard for completeness, citing 5 of 6 programs, and thirteen AAAs cited only two or three programs. The qualitative data further indicated a lack of completeness and accuracy. This suggests a need for standardized, statewide training. Also, options counselors should have technology that helps them perform well, such as the web-based system recommended. Finally, when citing options, most of the AAAs first cited the programs they offer and only cited other programs when prompted. This suggests the appearance of bias that could be minimized by performance monitoring and reporting to MDHHS and the public. *Comprehensive* options counseling is possible and an essential component of an effective LTSS system. The lack of comprehensive options counseling diminishes the lives of people who need services and their families. It also contributes to ineffective and inefficient LTSS and stands as a barrier to developing the LTSS *system* Michigan needs.

Opportunities

- MDHHS’s plan²⁷ for using the federal ARPA funds includes possible investments which are subject to additional discussions with stakeholders, MDHHS executive leadership, and the state legislature. The investments include “conducting independent options counseling prior to patient discharge from a hospital,” conduct[ing] an education campaign to increase awareness ...of HCBS services,” “establish[ing] a statewide training and credentialing system for CLS providers...,” “employ[ing] CHW (community health workers) to support independent options counseling,” and “develop[ing] a Data and Quality Team to identify key indicators of quality and progress...” Each of these investments could be developed to contribute to the options counseling services that Michigan needs.
- In addition, CMS’s guidance on the use of ARPA funds includes examples such as building No Wrong Door systems; developing informational websites, automating screening and assessment tools; conducting marketing and outreach campaigns; providing person-centered planning training; embedding options counselors in hospital discharge programs; and developing health information technology care coordination enhancements. These options provide opportunities directly related to options counseling services and could be considered in MDHHS’s final plans.
- MDHHS recently conducted reorganizations that merged the Aging and Adult Services Agency, which administers the AAA network; the Medical Services Administration, which administers the Medicaid LTSS programs; and Behavioral Health and Developmental Disabilities Administration, which administers the Community Mental Health services. The resulting Behavioral and Physical Health and Aging Services Administration now administer all the MDHHS programs involved in LTSS. This could provide the collaboration necessary for a comprehensive options counseling service.
- The new administration is conducting a project to build on the lessons learned by five AAAs that are working with local hospitals to provide discharge planning and follow-up enhanced by the AAAs’ options counseling. This work provides an important, evidence-based component to options counseling services. (A. Gamez, personal communication, March 1, 2022)
- MDHHS has a Continuous Quality Improvement Design Team focused on independent options counseling. The design team includes community providers along with department staff, resources for data collection and analysis, and administrative support. The design team methodology is well-suited to much of the planning needed for success.

Recommendations

- 1** Developing options counseling services will be a major, long-term undertaking that will require leadership and staff specifically assigned to the challenge. The current MDHHS staff have relevant expertise but do not have the capacity to take on this added responsibility. MDHHS should invest in the human resources necessary for success.
- 2** As part of its ARPA planning, MDHHS must build stakeholder and legislative support for comprehensive options counseling services and develop a plan that fully utilizes the options provided by CMS for use of the funding. The investment ideas in the current plan could contribute significantly to the development of options counseling services. If MDHHS had a plan for options counseling, the ARPA spending plan could be more fully developed to target those components most suitable for ARPA funds.
- 3** The development of a web-based system to support options counseling will itself be a major, multi-year undertaking. ARPA funds could provide an aggressive start-up to this work. It would be entirely consistent with MDHHS's plan to "...focus on one-time or time-limited funding that support[s] initiatives with long term, structural impact." Also, the system recommended in this paper could be developed and implemented in stages and built as part of a multi-year plan.
- 4** Many of the components of options counseling services could be developed through pilot projects, such as the current work of AAAs with hospital discharge departments. It will be essential to develop the pilot projects from a comprehensive plan for options counseling services.
- 5** There are situations where options counseling will identify the need for rapid access to HCBS. This could occur during hospital discharge planning, a determination that a nursing facility resident is no longer eligible for Medicaid-funded care and must leave within 30 days, or an unpaid family caregiver is injured, and the family needs paid services for the first time. The MDHHS local offices and MI Choice waiver program could develop rapid response teams that would facilitate assessment and enrollment within a very short time.

Direct Care Workers

Options counseling works best when there are sufficient, viable options. Options counseling, as described in this paper, is also important even when options are limited. Options counseling can give a voice to individuals' choices and reveal the extent to which those are met by current options. Even when state resources are scarce and access to options is limited, individuals must know about possibilities so they can advocate for themselves and, in doing so, inform the state of unmet needs.

Michigan's current LTSS capacity could be improved in many ways. For example, flexible funding could more effectively support innovation in areas such as affordable, accessible housing; eligibility determination and program enrollment could be simplified and expedited; services that support community living could do more to support meaningful engagement with the community; and, of course, there could be more public support for spending on LTSS. This paper will focus on staffing as an essential component of system capacity because the current needs are extreme and pervasive, and the effects are harmful to individuals and their families.

The shortage of direct care workers is long-standing and well-known to providers and people who rely on services.²⁸ President Biden's Build Back Better plan recognized the value of direct care workers with a major investment in HCBS, including increases in workers' compensation.²⁹ While the HCBS investments were removed from subsequent versions, identifying care providers as essential infrastructure is an important message. Much of direct care work is provided by women, and people of color and, in Medicaid, provided to low-



Individuals seeking services may be denied admission or enrollment because the provider cannot assure adequate staffing.

income individuals.³⁰ The poor compensation for direct care workers has deep roots in paternalism, racism, and classism. The point here is that getting to fair and respectful compensation will take a carefully planned, long-term commitment to change the public's value of direct care work. Two-dollar and thirty-five-cent raises and signing bonuses are positive steps, but they must occur within a larger plan that will lead to livable wages, benefits, and better working conditions.



The capacity of the workforce affects the amount and quality of services available. Currently, individuals seeking services in any setting may be denied admission or enrollment because the provider cannot assure adequate staffing. Also, program beneficiaries may experience poor care because a nursing facility cannot reliably fill all the shifts, a home care provider does not have backup workers, there is not adequate training, or there is not enough time to provide the quality care that the workers see as their responsibility. The reasons for this shortage are well-known: low pay, poor benefits, difficult working conditions, and lack of training and career paths. And, as low-income workers, their work may be affected by inadequate transportation, lack of affordable childcare, housing insecurity, and other forces outside of their jobs. **The true value of direct care workers needs to be recognized by legislators, policymakers, and the public as profoundly as it is recognized by the people they serve.** This will take a long-term commitment to change public perceptions and build support and appreciation for direct care workers. That is the foundation necessary for making the major changes needed to fairly compensate and maintain an adequate workforce.

Opportunities

- Michigan's ARPA Home and Community-Based Services Spending Plan³¹ describes Phase 1 investments that began October 1, 2021, including funding for an additional 1,000 slots in the MI Choice waiver program. The plan provides preliminary lists of additional investments, pending additional discussions with stakeholders, MDHHS executive leadership, and the state legislature, for Phase 2 (to be finalized by October 1, 2021) and Phase 3 (to be finalized by October 1, 2022). Many of these investments could have a positive impact on the direct care workforce. They include:
 - Conducting an education campaign to increase awareness and availability of HCBS services. This could be designed to also increase the appreciation of the direct care workers.
 - Establishing a workforce capacity-building center. This could provide leadership for short- and long-term strategies and work across programs to avoid fragmented, program-specific efforts to enhance jobs.
 - Expanding the use of Community Health Workers to serve high-risk beneficiaries and provide independent options counseling services.
- Since portions of Michigan's ARPA plan have not been finalized, MDHHS could consider some of the uses of ARPA funding cited by CMS. Regarding workforce support, they include increasing provider rates, leave benefits and specialized payments, workforce recruitment strategies, and training.³²
- Recruitment and retention activities, such as incentive payments, and training, including person-centered planning training.
- Michigan has an abundance of stakeholders, ideas, and data. A report by the Center for Health Care Strategies cites six groups working to improve direct care workers' jobs.³³ It also cites multiple reports that provide data on many variables that affect the direct care workforce with sources that include interviews with direct care workers.



Recommendations

The Center for Health Care Strategies (CHCS) report provides many specific, compelling recommendations.³⁴ The following recommendations draw upon the CHCS paper:

- 1** MEJI recommends that Michigan develop a comprehensive plan to transform the direct care workforce. This transformation will include wage increases, training, and other strategies that enhance the experience of direct care workers, and it will also have a goal of transforming how direct care workers are viewed and valued. The CHCS report describes a culture change campaign (p.17) that would include talking about the workers differently in order to shape new perceptions (p.25). Progress on all the strategies will likely be slow and incremental, which makes a project plan essential to maintain focus, build momentum, and coordinate the efforts through clear roles for the activists, policymakers, and programs that rely on the workers. MEJI highly recommends the CHCS report for its “roadmap” (p. 18) and many specific recommendations.
- 2** Increase wages and benefits. The state must make a commitment beyond the temporary wage increases associated with the Public Health Emergency. Some of the direct care workers interviewed by CHCS expressed concern that strategies such as training and certification could be counterproductive if they place additional demands on workers before wages and benefits are increased.
- 3** The Michigan ARPA Spending Plan³⁵ states that Phases 2 and 3 will “...focus on one-time or time-limited investments that support initiatives with long-term structural impact.” (p. 8). MEJI recommends formally evaluating each investment for its impact on beneficiaries and state spending. The latter is complex because some savings accrue outside of the Medicaid program, but the data are necessary to demonstrate the value of the investments as a basis for building a long-term commitment to the initiatives.

Conclusion

This paper focuses on three areas that contribute to the barriers to accessing HCBS, funding methods for LTSS, options counseling, and the direct care workforce. There is a long history of efforts to address barriers and there are compelling reasons to act now. Michigan's poor performance in rebalancing LTSS spending, i.e., more overall spending on HCBS programs and less reliance on nursing facility services in response to individuals' preferences, and the Office of Inspector General's audit findings critical of MDHHS's financing methodology for nursing facilities argue for making changes to align funding with individuals' needs and create the flexibility for funding to follow individuals' choices.

The direct care worker crisis is a priority across stakeholder groups; it has been studied by researchers, and committees and coalitions have produced analyses and recommendations. The COVID-19 pandemic intensified long-standing problems but also generated federal responses, such as the ARPA funding, that can be used to make fundamental changes. Finally, the paper's primary focus is Michigan's profound need for comprehensive options counseling services. Options counseling, as recommended here, would inform and empower individuals and families by providing assistance as they face critical and complex decisions. Importantly, it would also provide the data on beneficiary priorities, choices, and outcomes; data that are necessary to drive state spending and assess the effectiveness of that spending. The ARPA funds provide a unique opportunity to build the foundations for options counseling services. The current conditions in LTSS demand action; they also provide opportunities to leverage funding and capitalize on lessons learned and the commitment of many stakeholders. **The question remains, if not now, when?**

References

- 1 American Rescue Plan Act of 2021, Public Law 117-2.
- 2 Gallagher, Elizabeth. Email communication RE: MI Choice Slots, November 2, 2021.
- 3 Eager, et al. v. Engler, et al. 2002.
- 4 Michigan Legislature, FY 2022 Budget, Michigan Public Acts of 2021, Act Number 87, Effective September 29, 2021.
- 5 Middleton, Wendi. Email communication RE: ADRCs, April 8, 2022.
- 6 Michigan Medicaid Long-Term Care Task Force, Modernizing Michigan Medicaid Long-Term Care; Toward an Integrated System of Services and Supports, May, 2005.
- 7 Michigan Medicaid Provider Manual, MI Choice Waiver Chapter and MI Health Link Chapter.
- 8 Roman, Courtney and Crumley, Diana. Forging a Path Forward to Strengthen Michigan's Direct Care Workforce, Center for Health Care Strategies, December 2021.
- 9 Luz, Clare. Email communication RE: Workforce accomplishments. April 14, 2022.
- 10 Mathematica. New Report: States Made Progress Rebalancing Medicaid Long-Term Services and Supports, but Major Opportunities for Improvement Remain. February 8, 2022.
- 11 Advancing Action: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, 2020, AARP Public Policy Institute.
- 12 Center for Disease Control and Prevention. Provisional COVID-19 Deaths by Sex and Age – DCD Data Sets. As of April 9, 2020.
- 13 National Academies of Sciences, Engineering, and Medicine. 2022. The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff. Washington, DC: The National Academies Press.
- 14 Ibid.
- 15 American Rescue Plan Act of 2021, Public Law 117-2.
- 16 Costello, Anne Marie, Centers for Medicare and Medicaid Services. SMD# 21-003, RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services During the COVID-19 Emergency. May 13, 2021.

-
- 17 Michigan Department of Health and Human Services. Michigan Home and Community Based Spending Plan; American Rescue Plan Act (ARPA) Enhanced Federal Funding. July 12, 2021.
- 18 Michigan Home and Community Based Services (HCBS) Spending Plan – Update. Michigan Department of Health and Human Services. May 5, 2022.
- 19 Center for Disease Control and Prevention. Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity. March 25, 2022.
- 20 Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. “Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019.” Chicago, IL: Mathematica, December 9, 2021.
- 21 Ibid.
- 22 Long-Term Care in America: Americans What to Age in Place, Associated Press-NORC Center for Public Affairs Research. May, 2021.
- 23 AARP, Despite Pandemic, Percentage of Older Adults Who Want to Age in Place Stays Steady, November 18, 2021.
- 24 Ringler, Doug A., Office of the Auditor General. “Administration of Medicaid Payments to Nursing Facilities for Long-Term Care; Michigan Department of Health and Human Services. Performance Audit Report. November, 2019.
- 25 Michigan Department of Health and Human Services. Medicaid Policy Bulletins, MSA 20-70, Nursing Facility Minimum Data Set (MDS) Submission, December 1, 2020.
- 26 Area Agencies on Aging Association of Michigan. <https://4ami.org/home>
- 27 Michigan Department of Health and Human Services. Michigan Home and Community Based Spending Plan; American Rescue Plan Act (ARPA) Enhanced Federal Funding. July 12, 2021.
- 28 Roman, Courtney and Crumley, Diana. Forging a Path Forward to Strengthen Michigan’s Direct Care Workforce, Center for Health Care Strategies, December 2021.
- 29 Watts, Molly O’Malley, Musumeci, MaryBeth and Ammula, Meghana. Medicaid Home and Community-Based Services: People Served and Spending During COVID-19. Kaiser Family Foundation, March 4, 2022.
- 30 Roman, Courtney and Crumley, Diana. Forging a Path Forward to Strengthen Michigan’s Direct Care Workforce, Center for Health Care Strategies, December 2021.

31 Michigan Department of Health and Human Services. Michigan Home and Community Based Spending Plan; American Rescue Plan Act (ARPA) Enhanced Federal Funding. July 12, 2021.

32 Costello, Anne Marie, Centers for Medicare and Medicaid Services. SMD# 21-003, RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services During the COVID-19 Emergency. May 13, 2021.

33 Roman, Courtney and Crumley, Diana. Forging a Path Forward to Strengthen Michigan's Direct Care Workforce, Center for Health Care Strategies, December 2021.

34 Ibid.

35 Michigan Department of Health and Human Services. Michigan Home and Community Based Spending Plan; American Rescue Plan Act (ARPA) Enhanced Federal Funding. July 12, 2021.

Appendices

A. MDHHS Long-Term Supports and Services Program Description and MEJI Addendum

Comparison of Home and Community Based Long Term Care Programs

Individuals who are eligible for Medicaid-Funded Long Term Care supports and services now have more choices. These include nursing homes, the Program for All-Inclusive Care for the Elderly (PACE), MI Choice, and MI Health Link. This chart compares the features of the programs that offer alternatives to nursing home care. The purpose is to allow individuals to make informed choices about the program that will best meet their needs. Not all programs are currently available in all areas of the state.

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
Individual must be eligible for admission to a nursing facility	Yes	Yes	No	Yes
Must have both Medicare and Medicaid to qualify	No	No	Yes	Yes
Combines Medicare and Medicaid Benefits	Yes	No	Yes	Yes

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
Expanded financial eligibility rules	Yes - individuals can have a gross income of up to 300% of SSI (\$2,349 per month in 2020) and still qualify for enrollment.	Yes - individuals can have a gross income of up to 300% of SSI (\$2,349 per month in 2020) and still qualify for enrollment.	No - unless the individual resides in a nursing home or is enrolled in the MI Health Link Waiver.	Yes - individuals can have a gross income of up to 300% of SSI (\$2,349 per month in 2020) and still qualify for enrollment.
The individual will have to meet a Medicaid Deductible (Spend-Down) to qualify for benefits	No - If you are eligible for Medicaid and your income is below the limit, you will not have a spend-down if you enroll in PACE.	No - If you are eligible for Medicaid and your income is below the limit, you will not have a spend-down if you enroll in MI Choice.	No - Individuals who have a spend-down are not eligible for MI Health Link.	No - If you are eligible and your income is below the income limit, you will not have a spend-down if you enroll in MI Health Link + MI Health Link Waiver.
Enrollment Start Date	PACE eligibility is confirmed and enrollment paperwork completed by the 24th, then PACE is active the first day of the next month.	No sooner than the date of the MI Choice assessment. Can be any day of the month, unless transferring from another long-term care program.	The first day of the month after MI Health Link eligibility is confirmed.	The first day of the month in which MDHHS approves MI Health Link + MI Health Link Waiver eligibility.

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
Disenrollment Rules	<ul style="list-style-type: none"> • Death • You no longer meet the eligibility criteria. • Disenrollment occurs on the last day of the month. 	<p>Can occur any day of the month. Common reasons:</p> <ul style="list-style-type: none"> • You are admitted to a nursing facility • Death • You no longer meet eligibility criteria • You have been in a hospital for 30 days • You chose another long-term care program 	<p>On the last day of the month, except the following situations in which the disenrollment is the day before the date of admission or placement:</p> <ul style="list-style-type: none"> • State Psychiatric Hospital admission • Incarceration (in prison, jail, etc.) • State Veterans' Home admission 	<p>On the last day of the month, except the following situations in which the disenrollment is the day before the date of admission or placement:</p> <ul style="list-style-type: none"> • State Psychiatric Hospital admission • Incarceration (in prison, jail, etc.) • State Veterans' Home admission
Covers Acute, Chronic, and Long Term Care needs	<p>Yes - services can be provided at home, throughout PACE contracted network* and PACE centers.</p> <p>*Contracted network includes many other community-based providers, including hospitals, specialists, nursing facilities, ambulances, dialysis, durable medical equipment, physical therapy and many more.</p>	<p>No - only covers long-term care. May enroll in hospice, but MI Choice does not cover hospice benefits.</p>	<p>Yes - except if the individual chooses hospice services, Medicare Part A and B and hospice services are covered under Medicare fee-for-service. The ICO covers all other services including Medicare Part D.</p>	<p>Yes - except if the individual chooses hospice services, Medicare Part A and B and hospice services are covered under Medicare fee-for-service. The ICO covers all other services including Medicare Part D.</p>

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
Services Available	<ul style="list-style-type: none"> • All Medicare and Medicaid covered services • All-inclusive services are needs-based and may include any of the following services:* • Personalized plan of care created, services provided and monitored by a 11 multi-disciplinary PACE team • 24/7 medical staff with access to full medical records • One-stop, coordinated care with preventive nursing services • Assist with Medicaid applications and recertification 	<ul style="list-style-type: none"> • Adult Day Health • Chore Services • Community Health Worker • Community Living Supports • Community Transportation • Counseling • Environmental Modifications • Fiscal Intermediary • Goods and Services • Home Delivered Meals • Nursing Services • Personal Emergency Response System • Private Duty Nursing/Respiratory Care • Respite Services 	<ul style="list-style-type: none"> • All Medicare services unless receiving hospice • All Medicaid State Plan services • Dental services • Hearing Aid coverage • Supplemental Services for individuals who do not meet nursing facility level of care or are not enrolled in the MI Health Link HCBS waiver: <ul style="list-style-type: none"> ◦ Adaptive Medical Equipment and Supplies ◦ Personal Emergency Response System ◦ Respite (14 overnight stays or 336 hours per 365 days) 	<ul style="list-style-type: none"> • All services in the “MI Health Link” column • Adaptive Medical Equipment and Supplies* • Adult Day Program • Assistive Technology • Chore Services • Environmental Modifications • Expanded Community Living Supports • Fiscal Intermediary • Home Delivered Meals • Non-Medical Transportation • Personal Emergency Response System* • Preventive Nursing Services • Private Duty Nursing Respite*

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
<p>Services Available cont.</p>	<ul style="list-style-type: none"> • No cost sharing for IDT/PACE physician approved prescriptions and home delivery • In-home clinical (nursing) and non-clinical support and services (chore services) • Adult day program on-site with activities, outings and memory care • Door-through-Door transportation to PACE center with assistance as needed • Coordinate, schedule and transport to medical appointments with assistance as needed • Adaptive medical equipment and supplies (Personal Emergency Response System) 	<ul style="list-style-type: none"> • Specialized Medical Equipment & Supplies • Supports Coordination • Training 	<ul style="list-style-type: none"> • Any additional optional services offered by the specific health plan. • Behavioral health and substance use disorder services through the Prepaid Inpatient Health Plans (PIHPs) 	<p>*MI Health Link HCBS waiver enrollees will not receive the services marked with the asterisk through the Supplemental Services listed in the MI Health Link column to the left. They will receive these services through the waiver, but not in addition to the Supplemental Services.</p>

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
<p>Services Available cont.</p>	<ul style="list-style-type: none"> • Behavioral health / counseling services / social work services • Nutritional counseling, meal preparation and home delivered meals • Urgent, primary and specialty care with on-site clinic • End of life care • Respite • Dental, vision, hearing foot care <p>*Other than emergency services, all services must be provided or authorized by PACE</p> <p>*May be responsible for costs of unauthorized or out-of-network services</p>			

Program Feature	PACE	MI Choice	MI Health Link	MI Health Link + MI Health Link HCBS Waiver
Where can services be provided?	<ul style="list-style-type: none"> • Home • PACE Center • Other Community-based settings • Nursing Facility • Hospitals 	<ul style="list-style-type: none"> • Home • Qualified Adult Foster Care Homes • Qualified Homes for the Aged • In the community 	<ul style="list-style-type: none"> • Home • Nursing Facilities • Offices of doctors or other providers • Hospitals 	<ul style="list-style-type: none"> • Home • Qualified Adult Foster Care • Homes • Qualified Homes for the Aged • In the community • Offices of doctors or other providers
Administering Agency (Website for looking up specific agencies)	<p>PACE Organization</p> <p>https://www.michigan.gov/mdhhs/assistance-programs/healthcare/seniors/program-of-all-inclusive-care-for-the-elderly-pace</p>	<p>Waiver Agency</p> <p>https://www.michigan.gov/mdhhs/assistance-programs/healthcare/seniors/michoicewaiver/mi-choice-waiver-program</p>	<p>Integrated Care Organization</p> <p>https://www.michigan.gov/mdhhs/doing-business/providers/integrated</p>	<p>Integrated Care Organization</p> <p>https://www.michigan.gov/mdhhs/doing-business/providers/integrated</p>

Comparison of Home and Community-Based Long-Term Care Programs, Addendum

The chart identifies the four programs that provide an alternative to nursing home care in that, like nursing homes, these programs require applicants to meet the MDHHS Nursing Facility Level of Care Determination (LOCD) criteria. For many people, the Home Help program is also an alternative to nursing home care, but it does not require applicants to meet the LOCD criteria.

Program Feature	Home Help Personal Care Program
Individual must be eligible for admission to a nursing facility	No
Must have both Medicare and Medicaid to qualify	No
Combines Medicare and Medicaid Benefits	No
Expanded financial eligibility rules	No
The individual will have to meet a Medicaid Deductible (Spend-Down) to qualify for benefits	Yes, if the person's income exceeds the Medicaid financial eligibility level.
Enrollment Start Date	No sooner than the date of the Home Help assessment. Can be any day of the month, unless transferring from another long-term care program with more rigid enrollment/disenrollment dates.
Disenrollment Rules	Can occur any day of the month. Common reasons: <ul style="list-style-type: none"> • You are permanently admitted to a nursing facility • Death • You no longer meet eligibility criteria • You no longer want services • You chose another long-term care program

Covers Acute, Chronic, and Long-Term Care needs

No, only long-term care

Assistance is available if you are eligible for Medicaid and require physical assistance with at least one activity of daily living. An adult services worker will complete an assessment in your home to determine whether you qualify for assistance through the Home Help program. Some of the available services include:

Available Services

The Home Help program **may pay** for the following activities of daily living:

- Eating or feeding
- Bathing
- Dressing
- Grooming
- Moving throughout the home
- transferring from one position to another
- Using the toilet
- Complex Care (including catheters, leg bags, colostomy care, bowel program, suctioning, specialized skin care, range of motion exercises, peritoneal dialysis, wound care, respiratory treatment, ventilators, or injections).

Services Available

If you qualify for one of the above activities of daily living, you **may also** receive assistance with the following:

- Administering or setting up medicine
- Laundry
- Light housework
- Meal preparation/clean up
- Shopping for essential items
- Travel for shopping/laundry

Services Not Covered

The following services are not covered by Home Help:

- Heavy housework
- Home repairs
- Prompting or reminding someone to complete a task
- Supervision
- Transportation
- Yard work

Where can services be provided?

- Home
 - Workplace
-

Administering Agency (Website for looking up specific agencies)

<https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/independent>

C. Web-based Options Counseling System Model

Use of the term “system.” This paper describes a web-based computer **system** that would be central to the infrastructure of options counseling services for older adults and individuals with disabilities. The paper also refers to a **system** of long-term supports and services (LTSS). While Michigan has an array of LTSS programs, they do not operate in a rational system of defined relationships between programs, inputs, processes, outputs, and outcomes. Options counseling is an essential component of an effective LTSS system of services, and the web-based computer system described here would provide the necessary infrastructure.

System Needs for Long-Term Supports and Services

Individuals need to make timely, well-informed decisions. There is no statewide, reliable source for comprehensive, unbiased information about options for individuals and families that have or anticipate the need for long-term supports and services. Individuals now encounter a maze of service systems and programs that are not readily identifiable, have complicated and overlapping eligibility criteria, have lengthy and demanding enrollment processes, and, if not navigated successfully, can result in poor health outcomes, family crises, avoidable hospitalizations, institutional care, and inefficient use of family resources and state funding.

The state needs to know the choices, needs, and experiences of the LTSS population to ensure the most effective use of state resources. The Department of Health and Human Services does not have a source of data on the choices, needs, and experiences of individuals seeking long-term supports and services. Anecdotally, we know that people are denied services or receive fewer services than they need for a variety of reasons, program practices vary throughout the state, people reside in nursing facilities who want to receive services in their homes, and families are overwhelmed by the care needs of a relative and frustrated in their attempts to find help. The lack of data is a barrier to using state funds most effectively and to convincing decision-makers of the need for greater investments in long-term supports and services.

Options counseling organizations need credibility to build upon effective performance and transparent operations. The organizations that currently have a role in options counseling, through information and assistance services, person-centered planning, beneficiary assessments, and other related activities lack the capacity in terms of staffing, training, and technology. They operate in bureaucratic silos, often reinforced by the organizations’ names, that function as barriers to individuals seeking services. In organizations that also provide services, they operate with the appearance of conflicts of interest.

The Infrastructure for an LTSS System

The technology exists to create a system that addresses the three overarching needs described above. The system could support the options counselor by providing:

Support for the OC process. The system would include an algorithm that guides the conversation to ensure responsiveness to the caller's priorities, such as urgency, specific information needs, or a broader exploration of priorities, choices, needs, and options. The system would allow for efficient data collection and access to a full range of information, from local service organizations that install ramps to the eligibility requirements for various state programs. The system would be flexible enough to allow for a natural conversation while assisting the options counselor in tracking information gathered and still needed. The system would support a process that is completed in one phone call or continued over a series of meetings with different staff members. The system would also prompt follow-up and closure activities to ensure optimal outcomes for the caller. Finally, the system would include a public portal that would empower individuals and families with information about caregiver support, service options, eligibility requirements, performance standards for providers, examples of best practices, and more.

Data for MDHHS systems management and resource utilization. The system would also address the needs of MDHHS by compiling data about callers, their choices and needs, the services they access, their health outcomes, and their satisfaction with options counseling and other services. This would reveal unmet needs, racial disparities, regional differences, best practices, and opportunities for program development. This information would provide critical input to funding decisions with the aim of aligning state spending with the needs and choices of individuals. This information could be provided through regular management reports and a public dashboard.

Data for OC operations and quality improvement. The system would also support the state's monitoring of options counseling services and options counseling organizations' management of their operations. Performance data could include call wait times, dropped calls, completeness of the information provided, caller satisfaction, and other measures. The performance data could identify resource and training needs. Training could also be embedded into the system.

Options Counseling System Development

First, a plan for the LTSS system. As described in the first paragraph, options counseling is an essential component of an effective and efficient system of long-term supports and services. MDHHS needs a vision for Michigan's LTSS system and a plan for achieving it. The development of this web-based system would be based upon that vision.

Stakeholders as partners. The OC system would be developed and deployed with ongoing input from standing advisory committees made up of service consumers, families, and advocates; options counselors and IT staff from their organizations; and long-term supports and services providers. The OC system could be developed, tested, and implemented in stages and in regional pilots. For example, the information on state program options might be developed first, followed by local options, and the consumer and family portal might be developed last after the core functions have been refined.

Integration with other LTSS data systems. The OC system would interface with CHAMPS, BRIDGES, and, possibly, other state systems. An options counselor wanting to follow up on a caller referred to the MI Choice program would know if the individual was enrolled, maintained eligibility, hospitalized, or discharged to a nursing facility. This could lead to helpful follow-up contacts from the options counselor. It would also allow for management reports that identified areas within the LTSS system that presented problems or exemplary performance.

Incorporate current best practices. Throughout the current service programs, there are organizations with strengths in various aspects of options counseling. For example, there are Area Agencies on Aging that have productive relationships with their local hospital systems to enhance patient discharge with options counseling and follow-up services. There are also lessons learned from earlier efforts to develop Aging and Disability Resource Centers and the Single Point of Entry pilot program that should inform the development process.

Evaluation and Continuous Quality Improvement. The data generated throughout the development and implementation of the web-based OC system would be used to evaluate the OC system itself, as well as the functioning of the LTSS service system. It will be critical to evaluate the web-based OC system and options counseling services as broadly as possible. Options counseling services will require a significant investment of state resources. Therefore, there must be a thorough analysis of the benefits of OC services wherever they are realized, including LTSS, primary care, and family health and finances. The stakeholder advisory groups could contribute to defining evaluation criteria, analyzing data, and developing quality improvement strategies.

