

**INDEX OF DOCUMENTS**  
**LONG-TERM CARE SUPPORTS AND SERVICES**  
**ADVISORY COMMISSION**

July 23, 2007

EXECUTIVE COMMITTEE MINUTES 05-29-07

OLTCSS UPDATE

REQUEST FOR LETTERS OF SUPPORT FOR THE TWO  
NEW REAL CHOICE SYSTEMS CHANGE GRANTS

LTC ISSUES FORUM NOTICE

DIRECT CARE WORKFORCE INITIATIVE (DCWI) POWER  
POINT PRESENTATION

DCWI RESOURCE SHEET

ADDRESSING THE ISSUE OF LONG-TERM CARE AS BABY  
BOOMERS AGE

OVERVIEW OF PREPAID LTC HEALTH CARE PLAN  
CONCEPT PAPER

NORTHWEST MICHIGAN COUNCIL OF GOVERNMENTS  
PUBLIC TESTIMONY

TAMESHIA BRIDGES PUBLIC TESTIMONY - HEALTH  
INSURANCE FOR HOME HELP PROVIDERS

LONG-TERM CARE SUPPORTS & SERVICES ADVISORY COMMISSION  
EXECUTIVE COMMITTEE  
JULY 2, 2007  
MINUTES

**ATTENDEES:** Andy Farmer, Hollis Turnham, Chris Chesny, Jackie Tichnell, Gloria Lanum, Jon Reardon

**June Commission Debrief**

- MI Choice overspending - Reardon would like a more substantive response to this issue. He has sent a letter to Head regarding this issue, with a copy to Farmer. Farmer asked that a copy of the letter be sent to Chaney, as Commission secretary.
- SPE Board membership - the Office indicated that the tables that were distributed at the Commission meeting might not be accurate. They are working on getting more information. Executive Committee is interested in how the Office will follow-up on this issue.
- LTC Partnership - There was discussion regarding the need for providers on this workgroup. This led to a discussion of the Office needing to get providers on other workgroups, as well. Farmer will talk to Head regarding this issue.
- Public testimony - Legal Immigrants and Health Care - Farmer talked to Abouzahr about this issue. He is meeting with her later this month. More information and research is needed before the Commission can discuss this issue.

**July Meeting -**

- Certificate of Need - this should be a separate discussion from the Office updates.
- Legislation on Estate Recovery/Preservation - Head made a request to DCH for a legislative presentation on this issue.

- Direct Care Workforce Initiative - this group would like 20 minutes to introduce themselves and their projects to the Commission. Farmer and Turnham will work on this issue for the July meeting.
- The Commission chair should probably do a roll call at the Commission meeting to verify attendance.

**Detroit Meeting, September 24** - McKinney will work with the Grace Temple to see if they are available. The Office will also see if there is anything available for that day. It is anticipated to be an all day meeting with the morning to be used for public comment. (This will not replace public comment time during the Commission meeting.) A place should be decided on by July 23. A Farmer will draft a notice to include preference of comments on the Task Force recommendations. The notice will be distributed by various means using advocacy organizations.

### **Workgroup Development -**

- Sign Up Trends - two of the groups have approximately 20-21 signed up. It is unsure if all these want to actually participate or monitor the workgroup. The Chairs should let Farmer know if no one has volunteered to participate in a workgroup.

Turnham indicated that Paraprofessional Healthcare institute has funds available for direct care workers to attend at least the finance and workforce workgroups. These funds would cover lost wages and mileage. Turnham will pursue for other workgroups as well.

- Charges - Chaney and Turnham are working on this. It is hoped to have a discussion document for the July meeting. There should be an open conversation about these charges with the chairs.
- Chair Retreat - This is a new item for discussion. It was decided this would best be served after the first meeting with the workgroups. Further discussion on this issue is required.
- Meeting Times - It was suggested that the Commission meetings and the workgroup meetings should alternate months. The time commitment for the participants needs to be put on the agenda for the

first workgroup meetings. It was noted that the workgroups still need statewide stakeholder approval of workgroup progress.

- **Staff Support** - The Office should check the availability of support services for the workgroups. This would include minutes, setting conference calls, making copies, sending meeting notices.

**Farmer Meeting with Head** - Farmer meets with the Office Director after the Commission meeting and before the Executive Committee meeting. Future discussions will focus on the coordination of office and Commission workgroup activities to seek better alignment of those efforts.

The next Commission meeting is July 23, 2007.

OFFICE OF LONG-TERM CARE SUPPORTS & SERVICES  
Update for the Long-Term Care Supports and Services Advisory  
Commission  
July 23, 2007

1. Long-Term Care Connections (LTCC) Projects
  - a. Service Delivery - During the month of May, over 2,300 calls were received and assistance was provided by the Information and Assistance staff, and over 500 persons have received Options Counseling.
  - b. Evaluation - The draft Information and Assistance consumer survey will be pilot tested. The Evaluation Steering Committee is also reviewing draft surveys to measure the outcomes that were identified for Options Counseling.
  - c. Training - Rhonda Montgomery and her staff conducted two-day training on how to assess and meet the needs of family caregivers in the Upper Peninsula. The training will be repeated in the fall, probably in the Grand Rapids area.
  - d. Contracts - Contracts have been signed with all of the three new Long-Term Care Connection independent entities in the three Lower Peninsula demonstration sites, as intended when the initial demonstration project awards were made. Contract and budget planning for FY 08 is underway.
  - e. Mandatory Level of Care – The Medical Services Administration (MSA) has promulgated draft policy that will state the LTCC agencies are the sole agency in the

specified regions to assess a consumer's functional/medical eligibility for nursing facilities and the MI Choice Waiver program.

## 2. System Transformation Grant Project

- a. The revised Strategic Plan was submitted to CMS. Their only response was that the State is required to obtain a project manager prior to receiving additional funding.
- b. A workgroup has been assembled to refine the Evaluation Plan. The Office has until August 3<sup>rd</sup> to submit the Evaluation Plan.

## 3. Office Development

- a. The Office submitted a request to fill several positions, including the Systems Transformation (STG) and Deficit Reduction/Money Follows the Person (DRA-MFP) project managers, to the state budget office. Approval to proceed with the Project Coordinator position to oversee the DRA-MFP and the Project Manager position to lead implementation of the STG project is being finalized this week.

## 4. Long-Term Care Insurance Partnership program

- a. Limited staff and other stakeholders will be attending a conference in July in Washington D.C., sponsored by the Center for Health Care Strategies.
- b. There have been two meetings of the workgroup. Initial work has been overview of the Deficit Reduction Act requirements for LTC Insurance Partnership programs, the

determination of methods to authorize qualified LTC Insurance Partnership policies in Michigan, and determination of the Medicaid State Plan requirements that must be addressed when that component is submitted. PA 674 of 2006 requires submission of this State Plan Amendment by October 2007.

## 5. MI Choice Waiver Renewal

- a. The renewal waiver package has been submitted to CMS for approval. CMS has 90 days to respond to the application. A copy of the renewal application can be found on the MI Choice Stakeholder Forum website:

<http://74.94.235.4:3455/michoice/9>

Make up a user name; password is: michoice

- b. The Specialized Residential Licensed Setting subcommittee continues to meet to examine the implications of placing into the MI Choice waiver a covered service option that will pay for special licensed residential settings (Adult Foster Care and Homes for the Aged).

## 6. Prepaid LTC Health Plan pilot project

- a. CMS approved a 6-month no-cost extension of the Monery Follows the Person grant which has supported this work, through March 2008.

- b. MSA and the Office of LTC Supports & Services are working together to assure completion of the feasibility study for this pilot project.

c. CMS has provided initial questions for response, to the concept proposal. Responses will be used to guide additional discussion with CMS.

7. Deficit Reduction Act - Money Follows the Person grant

a. A stakeholder group was formed to provide input on the Operational Protocol. This document is due to CMS in August.

b. A data workgroup has been meeting to define the data elements required by the grant and identify data sources for these elements.

c. The Office will be meeting with stakeholders to develop the nursing facilities transition pathway as part of the protocols development process.

d. CMS requires a Project Coordinator be on board before funding provided through this grant may be used.

8. Self-Determination in Long-Term Care

a. There are 69 persons with individual budgets who are applying options to directly select, employ and direct their care providers, across the four Pioneer sites.

b. The Office continues to train the other waiver sites on person-centered planning and methods to assure consumer options for self-determination in the MI Choice Waiver.

9. Person-Centered Planning Practice Guideline

- a. The comment period for the Person-Centered Planning Practice Guideline draft has ended. 19 individuals provided written feedback and suggestions. The Office is in the process of compiling the comments for finalizing the guideline, in collaboration with the MI Choice Waiver operations unit in MSA.
  - b. The guideline is intended to become a part of the FY 2008 MI Choice Waiver contract.
10. Other – applications for grant assistance
- a. The Office is working on submitting two new grant applications to the Centers for Medicare & Medicaid Services (CMS) this month.
    - State profile of its long-term care system
    - Person-centered planning enhancements
  - b. A Letter of Intent is being developed to be submitted to the Center for Health Care Strategies in order to become a participant state in collaborative efforts to expand states' knowledge and understanding of prepaid long-term care health plan models.

# MEMORANDUM

**Date:** July 23, 2007

**To:** Andy Farmer, Chairperson  
Advisory Commission on LTC Supports and Services

**CC:** Members, Michigan LTC Supports and Services Advisory Commission

**From:** Michael J. Head, Director, Office of LTC Supports & Services

**RE:** Commission support for two grant applications

The Department is developing applications in response to a solicitation from the Centers for Medicare and Medicaid Services for Real Choice Systems Change grants. This solicitation offers two grant opportunities: (1) State Profile Tool: Assessing a State's Long-Term Care System and (2) Person-Centered Planning Implementation Grants. We would like to include in each application a letter of support from the Commission, which would require your assistance and action at the Commission meeting on July 23.

Both grants would contribute to our implementation of the Long-Term Care Task Force's recommendations. The first grant has the potential to contribute directly to the work of the Commission, as well as the Department; the second grant would strengthen our implementation of person-centered planning in long-term care programs;

I have attached abstracts for each grant application and some brief guidance we are providing to letter writers. We are putting these applications together within a very short timeframe. Consequently, we need the letters of support by Wednesday noon, July 25. We are hopeful that the Commission will provide letters of support for each proposal.

Attachments

## Michigan's State Profile Tool for Long-Term Care

### ABSTRACT

Michigan's State Profile Tool for Long-Term Care grant will build upon Michigan's current long-term care system transformation efforts, which have as a foundation the Governor's Long-Term Care Task Force recommendations. Those recommendations are being realized through the state's single point of entry demonstration initiative, its Self-Determination in Long-Term Care Initiative, its CMS Systems Transformation Grant and other grants that all contribute to the state's direction for long-term care. Developing Michigan's State Profile will be a unifying process that will produce a clear qualitative and quantitative picture of the long-term care system at a time of fundamental change. The Profile will help manage and assess those changes and describe them to our many highly invested and engaged stakeholders. The Profile will focus on Michigan's long-term care populations of the elderly and adults with physical disabilities, while including the systems that serve adults with developmental disabilities or mental illness and children. The Profile will be useful in describing the interaction between systems, the relationship between populations, and the opportunities for closer coordination. The Profile will also include a special focus on the subgroup of individuals with dementia, as a group that receives services from more than one system and may benefit from a closer examination of the service options now available and outcomes experienced.

The second portion of the grant involves contributing to the development of national balancing indicators. Michigan currently has multiple initiatives that involve the development of management and evaluation data within the long-term care system, including single point of entry demonstrations, the MI Choice waiver quality initiatives, nursing facility transition services, and implementation of a pre-paid health plan model for long-term care. The work on national balancing indicators will help unify the department's various efforts to produce sound management information and reports, with the useful addition of common national measures that will allow comparisons across states. Michigan's contribution to this effort will be enhanced by our partnership with the University of Michigan's Institute on Gerontology, which is a national leader in the development and use of the Minimum Data Set for nursing facilities and home care and MDS-based quality indicators. Michigan also has a sophisticated data warehouse, which will be a vital partner in achieving the grant goals.

The grant goals include: (1) better integration of the planning and management of the state's long-term care systems change initiatives (2) development of integrated management reports on cost, utilization, quality and outcomes, (3) use of the State Profile and balancing indicators for describing the changing long-term care system to various stakeholder groups, (4) development of recommendations for strengthening services and outcomes for individuals with dementia, and (5) support for consumer participation in an on-going, data-based stakeholder dialog on long-term care balancing issues.

The grant partners will include the Michigan Public Health Institute, the Michigan Disability Rights Coalition and the University of Michigan Institute on Gerontology. The budget for the grant is \$505,263 for the three-year grant period. The budget includes \$480,000 in federal funds and \$25,263 in the state's in-kind match.

## **FY 2008 Real Choice System Change Grant: Person Centered Planning Implementation Draft ABSTRACT**

The, Office of Long Term Care Supports and Services, Michigan Department of Community Health is requesting funding assistance under the FY 2007 Real Choice Systems Change option to assure Person-Centered Planning Implementation.. This grant would enable a full implementation of **authentic** person-centered planning among all of the participants in the MI-Choice waiver. This work will also include assessing, developing and supporting the “informal” network of caregivers and community supports. Further, we will utilize funding to enhance our self-direction system and risk management processes.

Michigan has been a national leader in the use of a person-centered planning process beginning in its mental health and developmental disabilities service systems in the 1990's and expanding into the community based long-term care system with initial investments using Michigan's Independence Plus grant and through participation in the Robert Wood Johnson Foundation's "Cash and Counseling" expansion project. The result of this work has been first steps in person-centered planning process training and the development of a Person-Centered Planning Practice Guideline, being finalized for application in FY 2008 across Michigan's HCBS waiver for those eligible for nursing facility care. Additionally, Michigan is developing a statewide system of Long-Term Care Connection entities, beginning with four regional single points of entry entities to assist persons with long-term care needs. A central element of these first demonstration projects is use of a person-centered planning methodology in all encounters with those who need assistance in planning for long-term care needs.

This grant would enable Michigan to assess and refine Person Centered Planning to include the roles and needs of informal caregivers in the process. This effort will include determining useful caregiver assessment tools, and guidance on incorporating these into the PCP process for long-term care. Further refinement of PCP training curricula will be supported through the grant, including a consensus approach to develop a statewide capacity of independent facilitators of PCP, for use in Michigan's HCBS waiver sites and through its LTC Connection demonstration projects. Michigan expects to further enhance participant direction, deemed "Self Determination in Long Term Care", through the development of care-giver assessment tools that can best apply in the PCP process, and by development of a cadre of independent facilitators. Finally, the grant resources will support further evolution of quality management tools that can support continuous improvement in PCP practice quality using consumer feedback and local system mentoring from the consumer perspective.



**YOU ARE INVITED TO ATTEND  
THE  
LONG-TERM CARE ISSUES FORUM**

**THURSDAY, JULY 26, 2007**

AT THE

**Capitol View Building  
Conference Room A, B, C**  
210 Townsend Street, Lansing, Michigan

**9:00 am – Noon**

An informational session for stakeholders and persons interested in learning about & discussing:

- The status of developing a pilot project for a prepaid long-term care health plan model;
- Implementation planning for conducting the level-of-care eligibility determinations through Michigan's Long-Term Care Connection demonstration programs;
- The status of nursing facility transition activity and planning for implementing the federal Deficit Reduction Act - Money Follows the Person grant project.

**Sponsored by the Office of Long-Term Care Supports & Services  
Michigan Department of Community Health**

For More Information: 517.373.3860 or [thelen@michigan.gov](mailto:thelen@michigan.gov) **RSVP not required.**

## DRIVING DIRECTIONS

### July 26, 2007, Capitol View Building, Conf Rooms A, B, C

210 Townsend Street, Lansing, Michigan

The Capitol View Building is located on the southeast corner of West Allegan Street and Townsend Street. Parking is available, for a fee, in two city-run parking ramps. One ramp is located on Townsend Street, adjacent to the Capitol View Building. The other ramp is at the corner of West Allegan Street and South Capitol Avenue. Parking is also available at meters throughout the downtown area.

**From Grand Rapids:** Take I-96E to I-496E. Follow I-496E to the Pine Street Exit (Exit 6). Follow the off ramp to West Main Street and continue down West Main Street. Turn left on to Walnut Street (see map below).

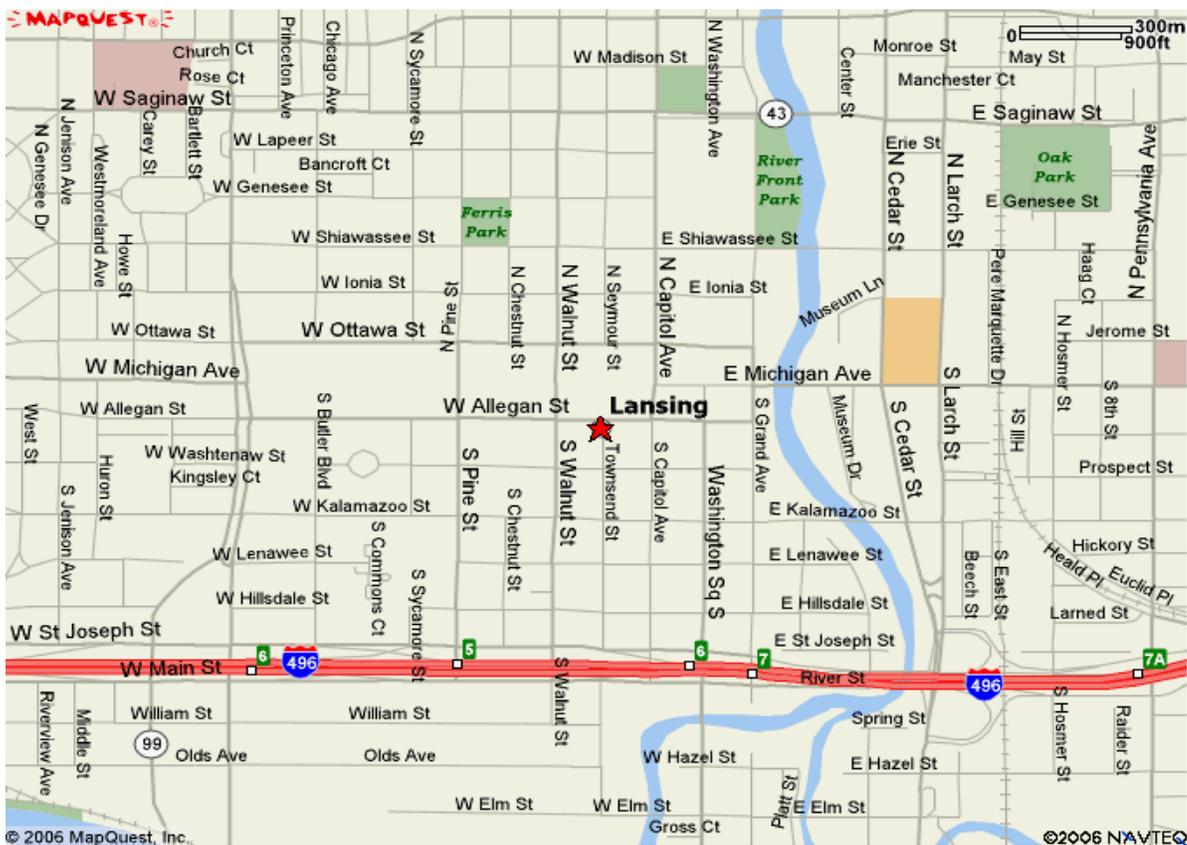
**From Clare and Points North:** Follow US-127S to I-496W. Take I-496W to the Walnut Street Exit (Exit 6). Follow the off ramp to West St. Joseph Street and continue on St. Joseph Street for one block. Turn right on to Walnut Street (see map below)

**From Flint:** Take I-69W to US-127S. Follow US-127S to I-496W. Take I-496W to the Walnut Street Exit (Exit 6). Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

**From Detroit:** Take I-96W to Lansing which runs right into I-496W. Get on I-496W and continue to Exit 6 which is Walnut Street. Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

**From Jackson and Points South:** Take US-127N from Jackson to Lansing. At I-96, I-496 will join US-127N. Follow I-496W to the Walnut Street Exit (Exit 5). Follow the off ramp to W. St. Joseph St and continue on St. Joseph St. for one block. Turn right on to Walnut Street (see map below)

**From Southwest Michigan (Kalamazoo-Benton Harbor-St. Joseph Area):** Travel North on I-69 to Lansing. Follow I-69 to I-496E. Follow I-496E to the Pine Street Exit (Exit 6). Follow the off ramp to W. Main Street and continue down W. Main Street. Turn left on to Walnut Street (see map below)





# Michigan Direct Care Workforce Initiative

---

CONSUMERS ● WORKFORCE ● PRACTITIONERS ● GOVERNMENT ●

# Goals for Today

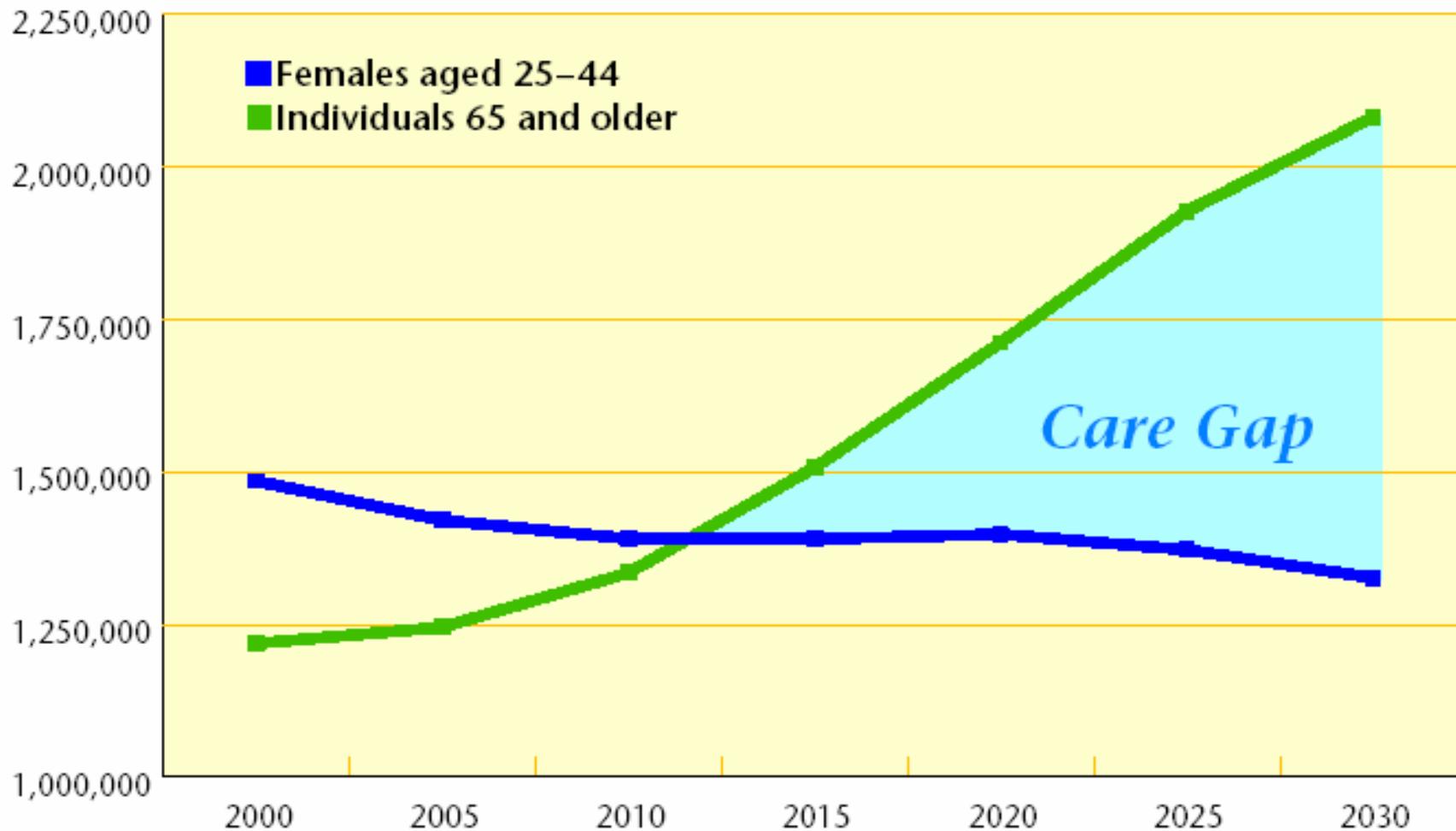
Introduce and offer ourselves as resource to the Long Term Care Supports and Services Advisory Commission

- ◆ Information
- ◆ Research
- ◆ Project Support

# Mission

The MDCWI serves as a conduit between public and private entities to develop, propose, promote and improve programs, services and policies to ensure a high quality, well trained and respected long term care workforce.

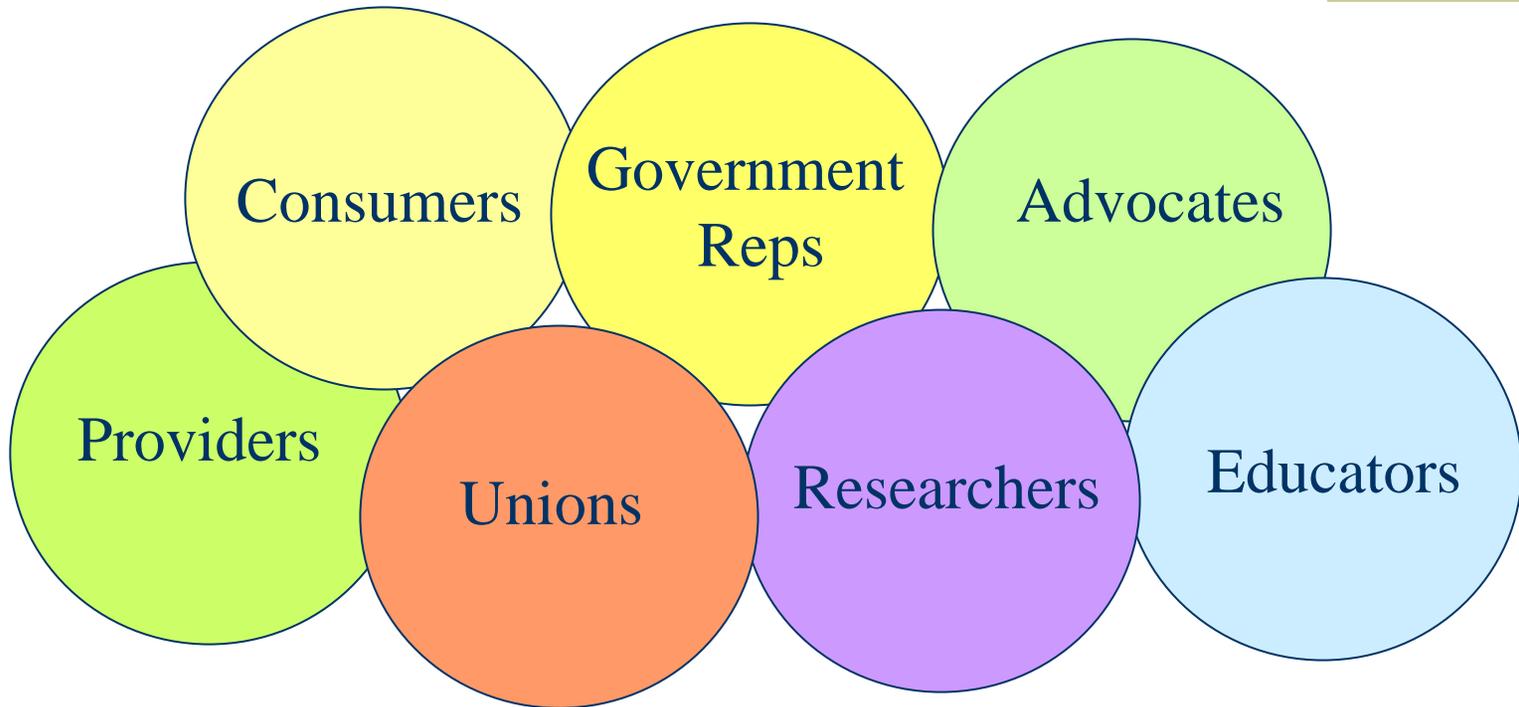
# Care Gap: Michigan



# MDCWI and LTC Task Force

To further enable our mission, the MDCWI supports the Michigan Medicaid Long Term Care Task Force's Workforce Development recommendations in the June 2005 final report.

# Members



# Values

- ◆ Collaboration
- ◆ Trust
- ◆ Willingness to work on agreed upon mutual goals and objectives
- ◆ Willingness to set aside personal agendas and focus on the greater good



# Elements

- ◆ Stakeholder development of strategies
- ◆ Exchange and promotion of best practices
- ◆ Development of models
  - recruitment, training, supervision and retention

# Starting Point

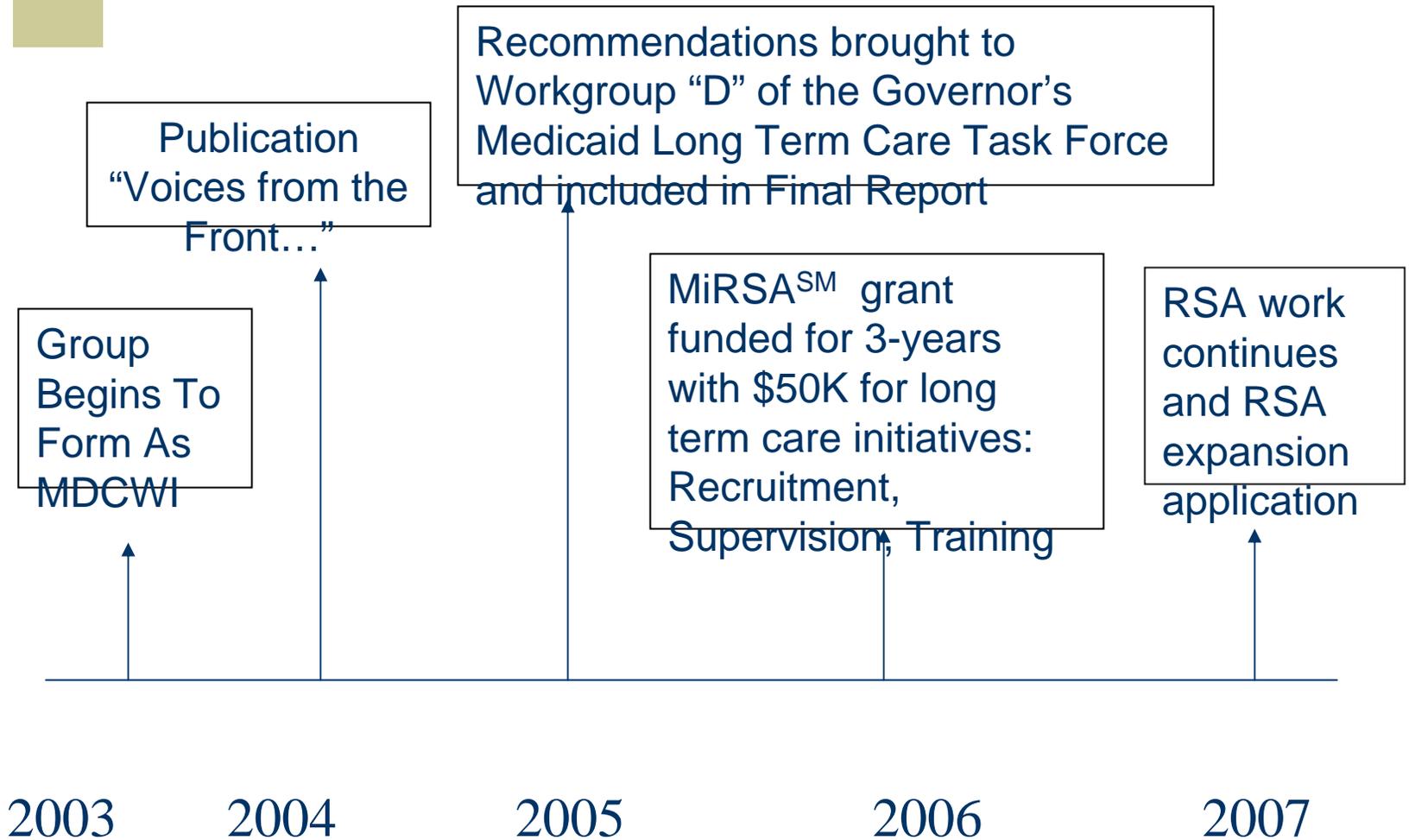
2003 -

Grant funded to assess recruitment, training, and retention methods of certified nursing assistants and home health aides

# Milestone

2004 –

Publication of *“Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan”*



# Michigan Direct Care Readiness Training Program (Healthcare) MiRSA<sup>SM</sup>

## ◆ Goals

- ✓ Pilot pre-employment program for potential direct care workers
- ✓ Develop and produce a management and supervision training curriculum directory and literature review
- ✓ Convene healthcare RSAs to evaluate updating Michigan's Certified Nursing Assistant Training Curriculum

# MDCWI—RSA Formed

2005—MDCWI receives funding (\$50,000) to implement a Regional Skills Alliance (RSA)—with three key goals.

1. Pilot a pre-employment program for potential direct care workers (DCWs)

Implemented by South Central Michigan Works!, BEAM and MDCWI Advisory Committee and evaluated by DDI/WSU

# MDCWI RSA Continued

2. Develop and Produce a Management and Supervision Training Curriculum Directory and Literature Review.
- It is currently listed on the Paraprofessional Healthcare Institute's Clearinghouse Website:  
[www.directcareclearinghouse.org](http://www.directcareclearinghouse.org)
  - Downloaded in 2006—678 times  
Between Jan-April 2007—272 times



# MDCWI RSA Continued

3. Convene the five direct care workforce/health care RSAs to receive their input on updating Michigan's Certified Nurse Aide (CNA) Training Curriculum

- Two Committees were formed:  
Phase I and Phase II



# MDCWI RSA--CNA Phase I

## CNA Phase I Curricula Committee

- Convened in December 2005
- Completed in April 2006
- Includes updates and emphasis on adult learner strategies



# MDCWI RSA--CNA Phase I

CNA Curriculum Website

[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

On the left side of the page are buttons for each of the boards/professions

Click on Nurse Aides and Scroll Down

Click on Nurse Aide Registration Information-it is here



# MDCWI RSA--CNA Phase II

## CNA Phase II Curricula Committee

- Developing plan and recommendations for strengthening the required competencies to meet resident's needs.



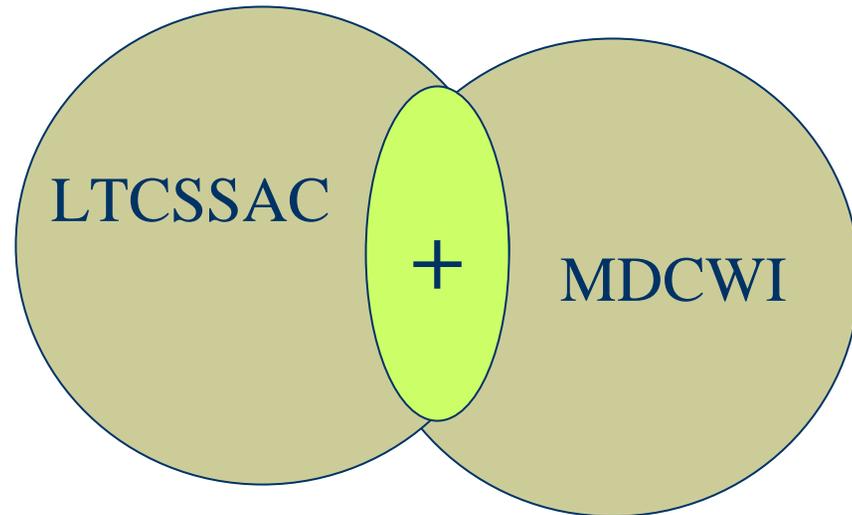
# Future Goals

- ◆ Expansion grant
  - Direct Care Worker Focus
- ◆ Implement Strategic Plan
  - Advocate and support
  - Lead change initiatives
  - Outreach
  - Research financing for long term support



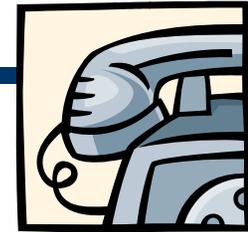
# What does this all mean?

- ◆ Advocacy
- ◆ Resource
- ◆ Support
- ◆ Research
- ◆ Projects



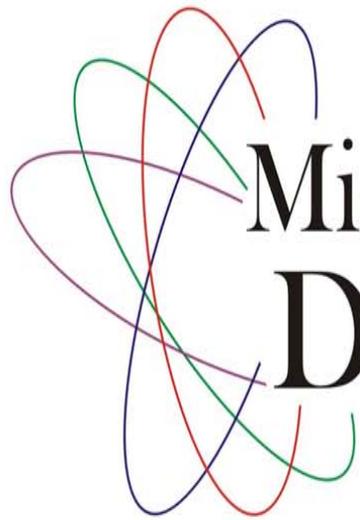
Furthering the Goals

# Contact Information



- ◆ Pat Anderson – Co-Chair
  - Healthcare Association of Michigan
  - patanderson@hcam.org
- ◆ Pam Gosla – Co-Chair
  - South Central Michigan Works!
  - pgosla@scmw.org
- ◆ Lauren Swanson
  - Michigan Office of Services to the Aging
  - swansonla@michigan.gov





# Michigan Direct Care Workforce Initiative

CONSUMERS ● WORKFORCE ● PRACTITIONERS ● GOVERNMENT ●

Thank You  
MDCWI Looks Forward  
to Working With The Commission  
To Address Workforce Issues

## RESOURCES

Michigan's Care Gap: Our Emerging Direct Care Workforce Crisis (April 2003)

*By Hollis Turnham & Steven L. Dawson*

<http://www.paraprofessional.org/publications/micaregap.pdf>

Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan

(April 22, 2004)

*By Maureen Mickus, PhD; Clare C. Luz, PhD; & Andrew Hogan, PhD*

<http://www.miseniors.net/NR/rdonlyres/EDEDAA1A-4646-4B6C-ACBC-44D666301F06/0/MDCWIVoicesFinalCopy.pdf>

Management and Supervision Training Curriculum Directory and Literature Review (2006)

*By Michigan Direct Care Workforce Initiative (MDCWI)  
Management and Supervision Committee*

<http://www.directcareclearinghouse.org/download/MDCWI%20Management%20Curriculum%20Directory%20and%20Literature%20Review.pdf>

Knowledge and Skills Needed for Dementia Care: A Guide for Direct Care Workers (2006)

*By Michigan Dementia Coalition*

[http://www.dementiacoalition.org/pdfs/knowledgeandskills\\_dementiacare.pdf](http://www.dementiacoalition.org/pdfs/knowledgeandskills_dementiacare.pdf)

Adult Abuse and Neglect Prevention Training (2007)

<http://www.mibeam.org/aanp/index.htm>

Updated Nurse Aid Training Model (*Revised 2006*)

[http://www.mi.gov/documents/mdch\\_na\\_train\\_curr\\_model\\_123067\\_7.pdf](http://www.mi.gov/documents/mdch_na_train_curr_model_123067_7.pdf)

## RESOURCES

Michigan State Planning Project for the Uninsured Project Report  
(August 2006)

[http://www.michigan.gov/documents/mdch/Project\\_Report\\_-\\_FINAL\\_182904\\_7.pdf](http://www.michigan.gov/documents/mdch/Project_Report_-_FINAL_182904_7.pdf)

Michigan Works! Association

<http://www.michiganworks.org/>

Michigan Regional Skills Alliance

<http://www.mi.gov/rsa>

# **Addressing the Issue of Long Term Care as Baby Boomers Age**

**House Senior Health Security &  
Retirement Committee**

**July 17, 2007**

**Michael J. Head, Director**

**Office of Long-Term Care Supports & Services**

**Michigan Department of Community Mental Health**

# Baby Boomers & LTC

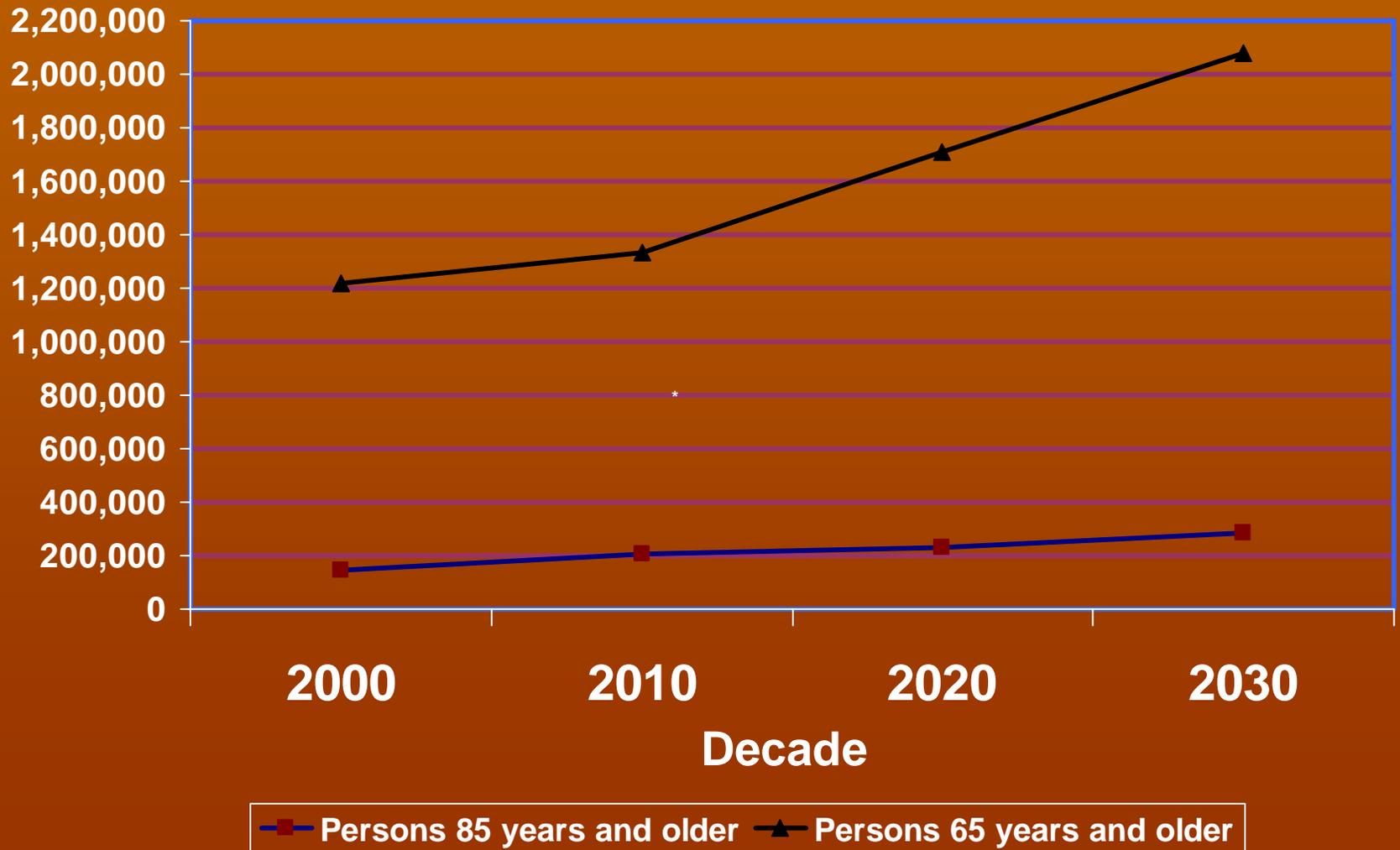
- Baby Boomers were born between 1946 and 1964. In 2006, the oldest of the baby boomers turned 60 years old.
- By 2040, Baby Boomers:
  - Over age 65 will double by 2040, to 77.2 M
  - Over age 85 will more than triple, to 14.3 M
- Those over the age of 65 who will need LTC will increase from 8.5M in 2000 to 12.1 million in 2040

# In Michigan

- Michigan's elderly population age 65 and older will grow:
  - 12.3% in 2000
  - 13.4% in 2010
  - 17.2 % in 2020
  - 20.9% in 2030
- The elderly population 85 years and older is projected to double between 2000 and 2030
  - 1.4% in 2000
  - 2.1% in 2010
  - 2.3% in 2020
  - 2.9% in 2030

# Michigan's Elderly Population

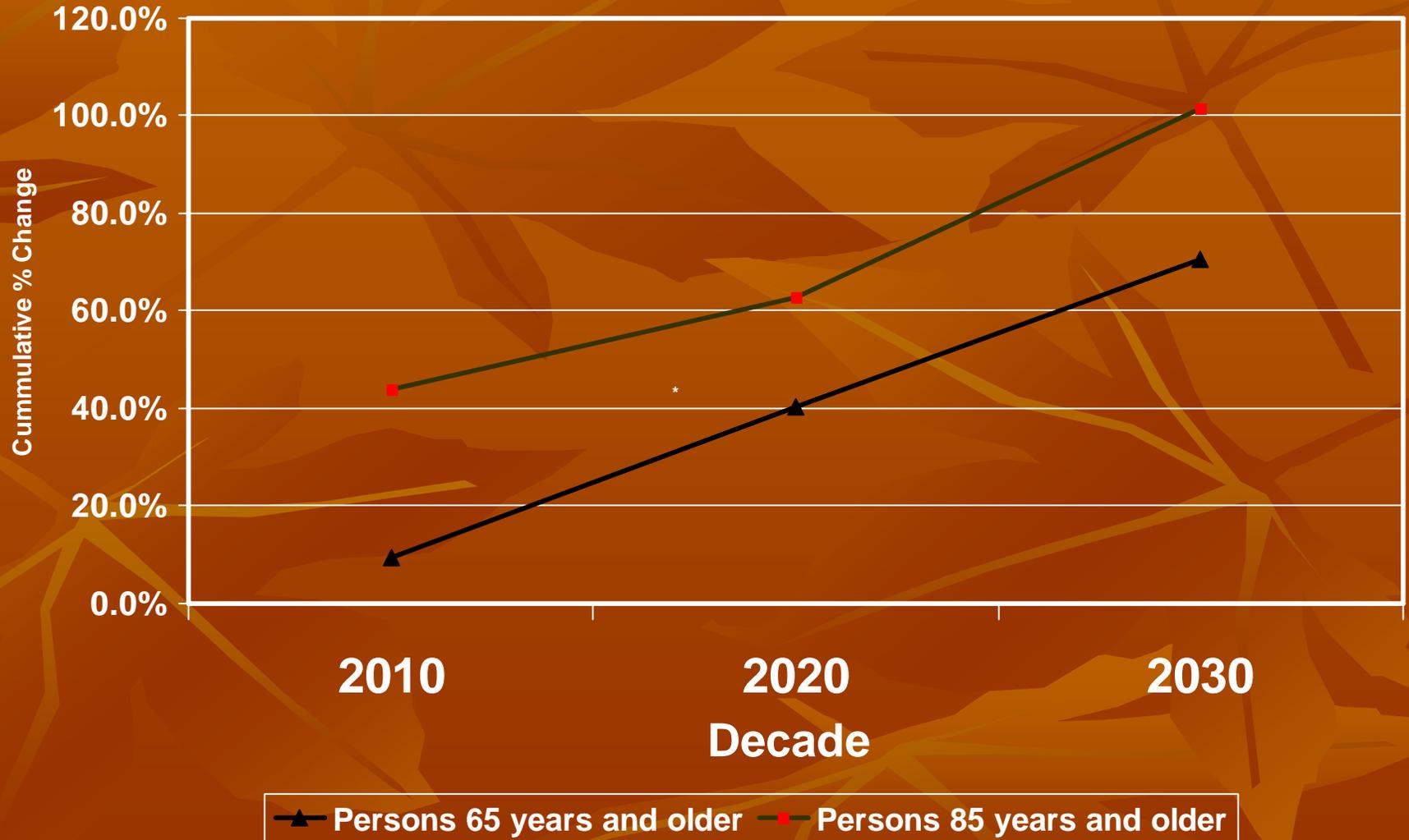
Population Estimates for Persons 65 + and 85 + Years of Age  
2000 – 2030



\* Source: U. S. Census Population Estimates, 2005

# Michigan's Elderly Population

Cumulative Percent Change in Estimated Persons 65 + and 85 + Years of Age  
2000 – 2030

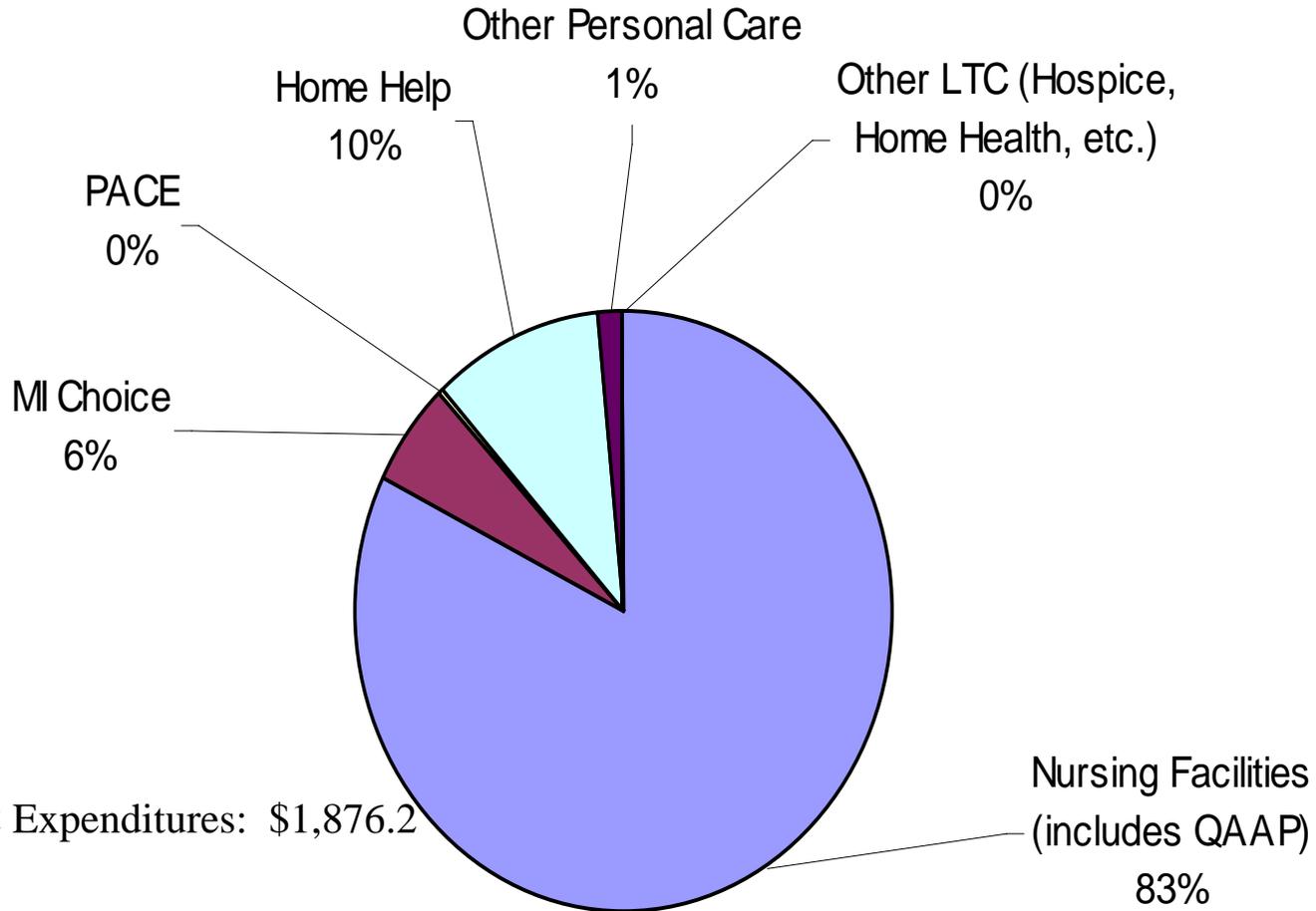


\* Source: U. S. Census Population Estimates, 2005<sup>5</sup>

# Further Perspective

- Somewhat fortunately the level of extended impairment (morbidity) is dropping, getting closer to the point of death. People who are elderly are staying healthy longer, with major impairments coinciding more with end of life.
- Earlier intervention and earlier disease management is reducing the effects of chronic disease on the need for care-giving until later in its course.
- Alzheimer's disease and dementia estimates will affect the type of LTC that people will need.

# FY 2006 LTC Expenditures



Total LTC Expenditures: \$1,876.2 Million

QAAP Revenue: \$218 M

# GOVERNORS LONG-TERM CARE TASK FORCE May 2005

- Require and Implement Person-Centered Planning Practices.
- Improve Access by Adopting “Money Follows the Person” Principles.
- Establish Single Point of Entry Agencies for Consumers.
- Strengthen the Array of Services and Supports.
- Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support and injury control, and (3) chronic care management and palliative care programs.
- Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.
- *Establish a New Quality Management System*
- Michigan should build and sustain culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams.
- Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.

# Governor's Executive Order

## 2005-14 June 2005

- The *Office of Long-Term Care Supports and Services* is created within the Department of Community Health to oversee all LTC policy and coordinate and organize LTC services
- A *Long-Term Care Supports & Services Advisory Commission* composed of a majority of consumer representatives shall be formed to advise on LTC policy.
- At least *three Single Point of Entry demonstration projects* shall be developed by July 2006.

# Actions to Address The Future

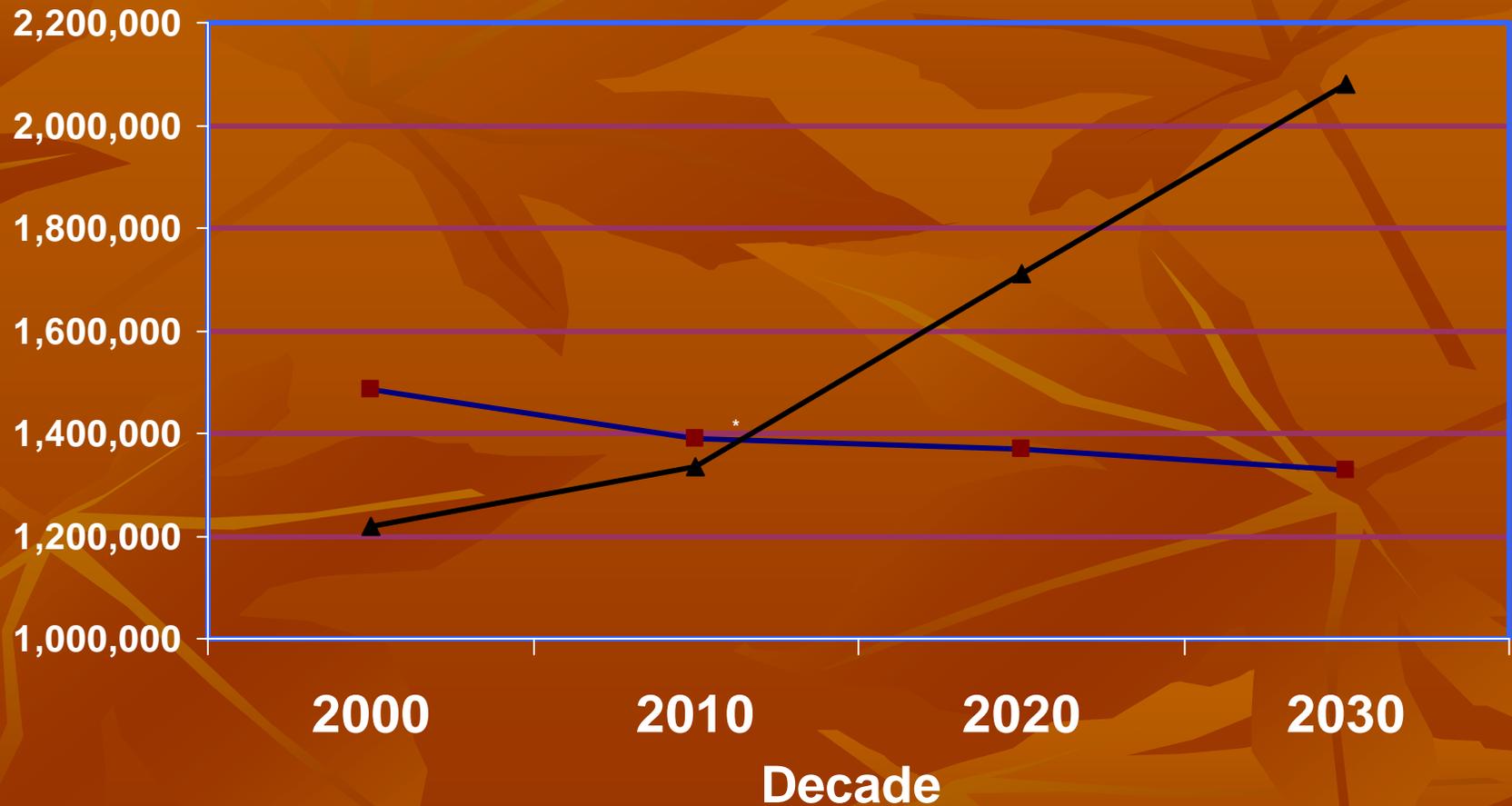
- **Single Points of Entry**
  - Provide an avenue for individuals and families to be better prepared
  - Serve as a gatekeeper for service access
  - Support individual choice based upon preferences and capacities
  - Follow those who need LTC along over the course of their LTC
- **Single Points of Entry need to expand beyond the demonstration projects and provide assistance across Michigan**
- **Expand home & community-based options to assure that those with companionship and supervision needs are provided with specialized residential care, rather than medical care**
- **Improve family support activities: Respite, Day Care**
- **Assure that individuals and families have support and encouragement to plan for their future LTC needs.**

# The Care Giver Shortage

- The number of potential care givers is dwindling.
- Michigan suffers from low wages and high turnover for paid caregivers.
- Need to enhance Certified Nurse Aide (CNA) curriculum, and negotiate with Feds for waiver to cover low wage direct care workers with health care.
- After 2010, a care giver gap is expected so that as the elder population grows, the number of younger workers available to care for them is expected to decline.

# Michigan's Caregiver Gap

Population Estimates for Women of Care giving Age and the Elderly  
2000 – 2030



■ Females age 25-44 ▲ Persons 65 years and older

\* Source: U. S. Census Population Estimates, 2005<sup>12</sup>

# Informal Care Givers

- Family has traditionally been the source of care-giving.
- The annual economic value of this informal care -giving is estimated at \$13.4 billion in Michigan alone.
- Recent AARP estimates of informal care-giving in MI put that amount at 1,280,000 which is nearly ` 13% of Michigan's population.

# Consumer Choice & Control

- Person-Centered Planning is central to LTC reform
- Supporting informed individual choice that aims to best address personal preferences is the goal
- Home and Community-based service options that support independent control over the selection and direction of providers have been shown to be highly desired
- Michigan is a “Cash & Counseling” replication state, developing options for consumer choice and control over services in the MI Choice Waiver
- Michigan’s option is termed “Self-Determination in Long-Term Care”
- Currently over 70 individuals in four MI Choice Waiver sites are controlling their services, directing the funds for their care to providers who work for them.
- In FY 2008, this option will be expanded across all of the MI Choice Program.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**PLAN FOR DEVELOPING A PREPAID MEDICAID LONG-TERM CARE**  
**HEALTH PLAN PILOT PROJECT**

**Values**

The Michigan Department of Community Health has based its planning for pre-paid long-term care supports and services on the following values:

- People should be fully included in community life and activities to the degree possible.
- People should be empowered to exercise choice and control over all aspects of their lives.
- People should be able to access quality supports and services when needed (not placed on waiting lists).
- All stakeholders, especially participants and family members, must be part of the planning and implementation processes.
- Person-Centered Planning is the basis for all plans of supports and services.

**Introduction**

The Michigan Department of Community Health, Medical Services Administration (MSA) has submitted a Concept Paper to the Centers for Medicare and Medicaid Service's Disabled & Elderly Health Program Group in the Center for Medicaid & State Operations (CMS) that would initiate discussions with CMS toward the Department's submission of 1915(b) and 1915(c) combined waiver applications. The purpose for this proposal is to create, under the Medicaid program, a prepaid health plan option that can establish a voluntary enrollment plan which, for eligible enrollees, will afford them access to a full array of long-term care supports and services determined in consultation with the enrollee, based upon enrollee needs and consistent with enrollee choices and preferences.

The intended outcome for utilizing a combined 1915(b)/(c) waiver mix is to replicate a model similarly structured in other states whereby enrollees have an entitlement access to home and community-based long-term care services as well as nursing facility services. The Department's Office of Long-Term Care Supports and Services has been the initial designer of the proposed plan, developing this option as a result of a CMS Real Choice Systems Change grant aimed at reducing "institutional bias" in Medicaid long-term care services and promoting "rebalancing" of the mix between institutional and home & community-based services for the elderly and persons with disabilities.

In 2005, Michigan's Governor, Jennifer M. Granholm, convened a Long-Term Care Task Force to identify consensus recommendations to modernize Michigan's Medicaid long-term care system. Part of the recommendations made by the Task Force included the following: 1) require and implement person-centered planning throughout the LTC continuum; 2) improve access by adopting Money Follows the Person principles; 3) establish single point of entry agencies for participants; 4) strengthen the array of supports and services; and 5) adapt financing structures that maximize resources, promote participant incentives, and decrease fraud.

A brief summary of key points are as follows:

- Collaborate among the local MI Choice Waiver agency, local Department of Human Services (for the Home Help Program), and local nursing facilities as well as other providers.
- Assure participant/family representation on the governing body.
- Development of single local system that authorizes and coordinates services across settings.
- Operate within a capitated financing arrangement.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**PLAN FOR DEVELOPING A PREPAID MEDICAID LONG-TERM CARE**  
**HEALTH PLAN PILOT PROJECT**

Key reasons (expected outcomes) for doing this are as follows:

- Enact “Money Follows the Person” within the Medicaid program for those eligible for long term care services.
- Improve quality of life options for people requiring services.
- Go beyond the capacity constraints of the current MI Choice Waiver Program.
- Provide entitlement access for persons eligible for the plan.
- Support participant choice and empowerment across a full range of supports and services
- Assure appropriate use of nursing facilities and home and community-based services.
- Provide local alternatives for nursing facility closures.
- Address unmet needs through reinvestment of savings.
- Manage the use of limited funding.

**Planning Principles**

- Supports and services should be community-based and should promote independence, community integration, and participation in community life.
- Continuously incorporate the participant’s voice (including family members when appropriate and in the participant’s best interests) in all aspects of plan development and implementation.
- Person-centered planning should always be fostered.
- Supports and services should be of high quality, non-discriminatory, culturally competent, and appropriate.
- People who meet nursing facility level of care need should not have to wait for home and community based services when that is their preference.
- Rights of individuals who are aging and/or persons with disabilities should be preserved and protected.
- Participants and their families should always be treated with dignity and respect.
- Health and welfare needs of participants must always be addressed.
- The model must assure high quality supports and services and demonstrate positive outcomes.
- DCH must evaluate the effectiveness of the model for possible statewide implementation.

**Feasibility Study**

A key function of the Money Follows the Person grant and a necessary part of the waiver application process is to conduct a feasibility study aimed at examining costs, efficiencies, supports, and barriers to implementing a Pre-paid Healthcare Plan for Long-Term Care.

The purpose of the Feasibility Study is to answer the following:

1. Will the proposed waiver program cost DCH more than current long-term care expenditures for current services to the same population and if so, how much more, than not proceeding with this plan?
2. What are the necessary financial outcomes for service delivery that must be met over a series of years for the program to be sustainable given current appropriations for long-term care services?
3. What have other states pursuing similar directions determined with respect to these same questions as they developed prepaid LTC health plan models?
4. What options might the state include to protect itself from financial exposure under the scenarios determined under questions (1) and (2)?
5. What might be the acceptable levels of financial and/or program success that would support an argument to continue the proposed model past a pilot program phase?

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**PLAN FOR DEVELOPING A PREPAID MEDICAID LONG-TERM CARE**  
**HEALTH PLAN PILOT PROJECT**

Enrollment in the long-term care PHP would be voluntary for participants. Those eligible would consist of the elderly (aged 65 and over), and persons with disabilities (aged 18 through 64) who meet existing MI Choice Waiver financial eligibility criteria and nursing facility level-of-care need. Incorporation of some type of participant fee, based on ability to pay, will be considered. This would be similar in concept to participant payment for a portion of nursing facility costs.

**Single Points of Entry (Michigan's LTC Connections)**

Michigan's Long-term Care Connections are the four demonstration Single Point of Entry entities developed over the past year at the direction of Governor Granholm and in conformance with PA 634 of 2006. These entities could serve as the screening and eligibility determination points for the proposed prepaid LTC health plan pilot projects.

**Developing a Service Provider (PHP)**

Successful implementation of this plan hinges on the Department identifying or developing an organization to serve as the Prepaid Health Plan (PHP). The PHP would provide Medicaid long-term care services in a limited geographic area. Ultimately the state may only contract with an entity qualified to meet CMS and state requirements for functioning as a capitated, risk-bearing entity.

The selection of a provider entity is a key factor for success of the overall effort. There does not appear to be an existing pool of PHPs with long-term care experience. Therefore, a bidding process is not warranted. Instead, it is intended that existing experience with LTC home and community-based services including nursing facility transitions could be partnered with an existing licensed HMO. There are a large number of stakeholder considerations including those of consumer advocate groups which need to be taken into account during the provider development process. Experiences in Wisconsin and other states provide a possible roadmap for this stage of development.

**Personal Outcomes for Participants**

Person-Centered Planning/Self-Determination Outcomes

- People have a broad array of service and support options.
- People are treated fairly.
- People are treated with dignity and respect.
- People choose their supports and services.
- People choose their daily routine.
- People achieve their objectives for daytime activities.
- People are satisfied with supports and services.

Community Integration Outcomes

- People choose where and with whom they live.
- People participate in the life of the community.
- People remain connected to family and other informal supports.

Health and Safety Outcomes

- People are free from abuse and neglect.
- People have the best possible health.
- People are safe.
- People experience continuity and security.

## Abstract

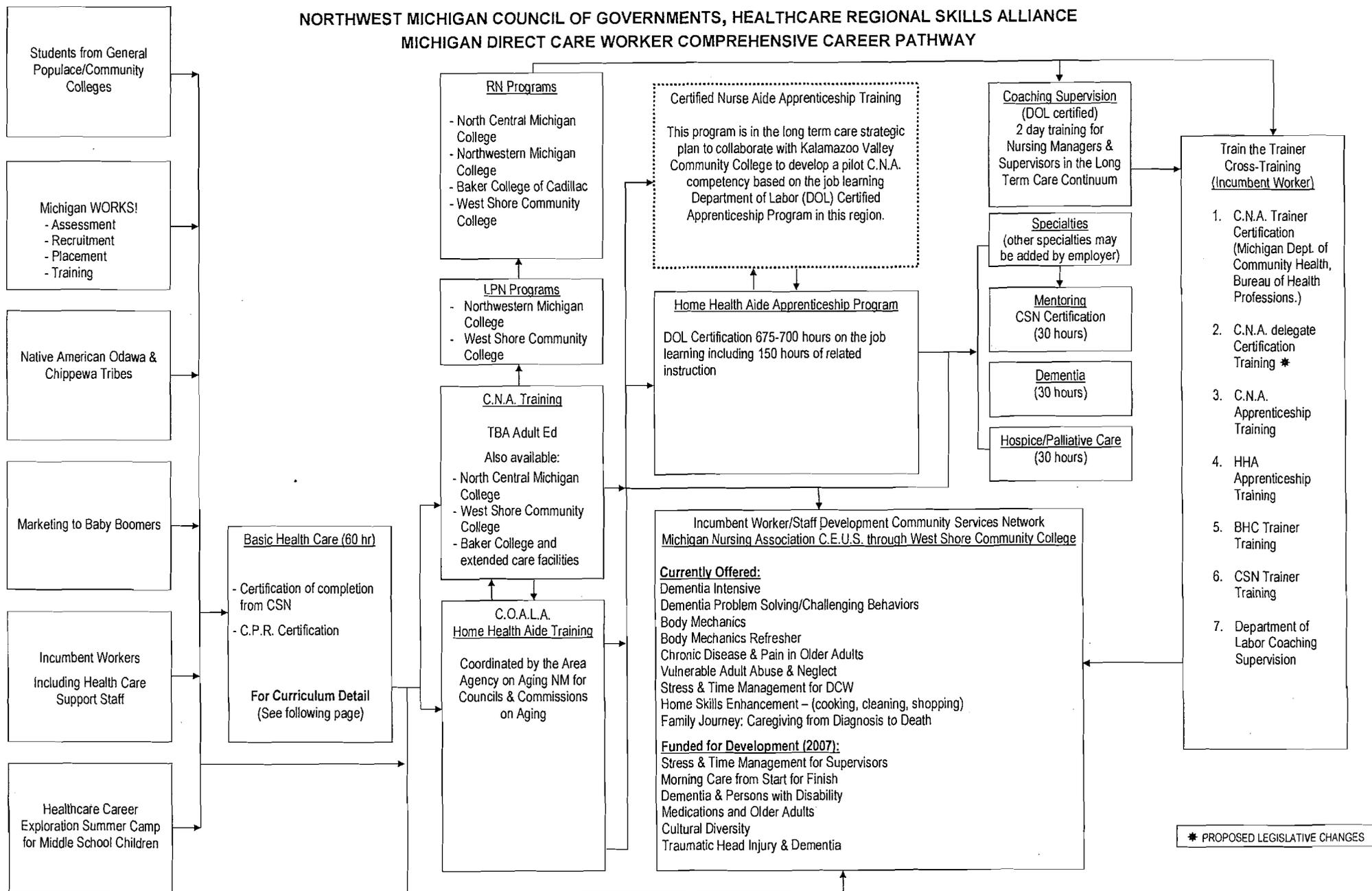
- The project applicant is the Northwest Michigan Council of Governments (NWMCOG), a regional unit of government which is the administrative entity for the ten-county region's Workforce Development Board and one-stop workforce development system, called *Michigan WORKS!*. The requested funding level is \$500,000.
- NWMCOG is also the convener for the Healthcare Regional Skills Alliance of Northwest Michigan, a collaborative partnership since 2004 of over 100 healthcare organizations and individuals including: workforce development agencies, hospitals, community and private colleges, adult education, career tech centers, Area Agency on Aging Northwest Michigan, commissions and councils on aging, home health agencies, adult foster care homes, assisted living facilities, extended care facilities, community mental health agencies, hospice, the Grand Traverse Band of Ottawa and Chippewa Indians, the North Central Council of the Michigan Health and Hospital Association, and professional healthcare training partners.
- The healthcare sector is this region's fastest growing and highest need industry; the region's disproportionately high population of residents over age sixty (20% compared to 11% statewide), in combination with the depletion of the available workforce, is alarming.
- Training direct care workers in this vast, rural, low density region is a challenge for healthcare providers, trainers and the student or direct care worker.
- The overall strategy is to implement and coordinate a comprehensive direct care worker career pathway that meets the needs of all direct care providers with a career ladder/lattice of certified/credentialed training for potential and incumbent workers. Other key strategies are:

- Begin the direct care worker career pathway with a 60 hour Basic Health Care training that gently recruits, orients and screens potential workers to the real world of long term care, including the challenges and rewards;
  - Provide credentialed and certified training taught by trainers who are “universally” competent in both home care with the COALA & Home Health Aid (HHA) Apprenticeship and extended care settings with Certified Nurse Aid (CNA) Certification;
  - Offer both HHA and CNA opportunity for Specialties 30 hour certificate training intensive in Dementia, Hospice and Mentoring;
  - Offer incumbent worker training on 16 substantive topics (nursing C.E.U.’s) for low cost;
  - Provide annual 2-day PHI Coaching Supervision course for nursing supervisors; 88% of healthcare providers, including hospitals, stated in the provider survey they would “definitely benefit” from this training;
  - Utilize curricula with a person-centered care philosophy and an adult-learning theory context at an appropriate level for the learner;
  - Provide access to sparse training opportunities by offering mobile training, HHA skills testing lab, and other activities in various counties;
  - Educate healthcare providers with a “business case” for training their workforce;
  - Continue to fulfill RSA goals and collaboration with input from all partners at sub-regional town hall meetings about workforce needs.
- These proposed strategies to recruit and retain direct care workers through quality training will reduce staff turnover, increase capacity for quality of life for direct care workers and

those they serve, and improve the viability of the direct care industry, all via a regional strategic career path and innovative partnership.

- Key High Growth Job Training Initiative (HGJTI) partners are:
  - Northwest Michigan Council of Governments (NWMCOG) and its Workforce Development Board – provides administrative oversight, convener services, coordination of the partnership, and overall facilitation of the initiative;
  - *Michigan WORKS!* - provides recruitment, screening, assessment, job placement, and job training funds;
  - Adult Education Program – provides COALA and CNA training programs;
  - Traverse Bay Area Career Tech Center– provides facilities for both CNA and COALA training;
  - Private and community colleges – provide CNA, LPN and RN training programs;
  - Area Agency on Aging of Northwest Michigan (AAANM) – provides COALA home health aide coordination, networking and mentoring;
  - Harbor Home Care Agency – offers the DOL/PHI Home Health Aide Apprenticeship Program and participates in “specialty competencies;”
  - Community Services Network of Michigan (CSN) – nationally recognized for training, curricula development, and technical assistance;
  - Michigan Direct Care Workforce Initiative (MDCWI) – a coalitional/advisory conduit to improve recruitment, training & retention of all long-term care services.

**NORTHWEST MICHIGAN COUNCIL OF GOVERNMENTS, HEALTHCARE REGIONAL SKILLS ALLIANCE  
MICHIGAN DIRECT CARE WORKER COMPREHENSIVE CAREER PATHWAY**



\* PROPOSED LEGISLATIVE CHANGES



# When Michigan's Caregivers Lack Coverage:

*Findings from a Survey of  
Michigan's Home Help  
Workforce*

*Report to :*

The Michigan Quality Home Care Coalition

*By the:*

Paraprofessional Healthcare Institute

February 2007



[www.coverageiscritical.org](http://www.coverageiscritical.org)

---

# When Michigan's Caregivers Lack Coverage:

*Findings from a Survey of Michigan's Home Help Workforce*



## Table of Contents

<b>Acknowledgements</b> .....	<b>2</b>
<b>Executive Summary</b> .....	<b>3</b>
<b>I. Introduction</b> .....	<b>5</b>
<b>II. Survey Methodology and Data Sources</b> .....	<b>5</b>
<b>III. Background on the Michigan Home Help Program</b> .....	<b>6</b>
<b>IV. Survey Findings and Analysis</b> .....	<b>7</b>
<b>V. Implications</b> .....	<b>12</b>
<b>VI. Conclusion</b> .....	<b>14</b>
<b>Endnotes</b> .....	<b>15</b>
<b>Appendices</b>	
Appendix 1: General Demographic Information .....	<b>18</b>
Appendix 2: Employment Characteristics .....	<b>19</b>
Appendix 3: Geographic Designations .....	<b>20</b>



## Health Insurance Coverage Initiatives for the CMS Direct Service Workforce Demonstration Grants 2003 and 2004

	<b>Indiana</b> Arc Bridges, Inc.	<b>North Carolina</b> Pathways for the Future, Inc.	<b>Virginia</b> Department of Medical Assistance Services	<b>New Mexico</b> Department of Health, Long Term Care Services Division	<b>Maine</b> Governor's Office of Health Policy and Finance	<b>Washington</b> Home Care Quality Authority
<b>Approach</b>	<i>Subsidizing Employer-Sponsored Insurance</i>			<i>Reimbursement Arrangement</i>	<i>Outreach Initiative</i>	
<b>Health Care Intervention</b>	Offer \$50 per month to Direct Support Professionals (DSPs) for a cafeteria plan. Employees can use this money to reduce their share of their agency-sponsored health insurance plan or to cover or reduce the cost of a range of other benefit options.	Subsidize the employee share of health care premiums up to \$108 per employee per month.	Pay employer share of employer-sponsored health insurance plan for 75 workers, plus \$100 per child for workers who choose family coverage.	Offer a health care reimbursement arrangement package that includes three components: a basic health insurance plan, a prescription drug card, and monthly cash contribution of \$60 per month to a tax free health savings account.	Outreach to home care agencies to promote Dirigo Choice, Maine's new state subsidized health insurance program and other options for providing health coverage to direct-care workers.	Educate workers about the health care plans they are eligible for and assist them in enrolling in these plans through Referral Workforce Resource Centers (RWRCs). Workers have a choice of either a Multi-Employer Health Benefits Trust Plan (a Taft-Hartley Plan) or the Washington Basic Health Plan (BHP is a state-administered plan).
<b>Target Population</b>	251 eligible DSPs employed by Arc-BRIDGES, Inc.	300 home care workers employed by four partner agencies who were already offering insurance.	Up to a total of 75 direct-service workers employed by four home care agency.	350-400 DSWs employed by seven developmental disability service provider agencies who were not previously offering insurance. Can be used for family coverage.	26 home care agencies	6,027 independent providers (IPs) contracted to provide Medicaid funded services who are potentially eligible for health coverage based on the number of hours they work and who live in counties served by the 4 existing RWRCs. <sup>2</sup>
<b>Eligibility</b>	DSPs with at least 30 core scheduled hours per week who have been employed with the agency for 31 days	Home care workers who work a minimum of 30 hours per week	Employees of pilot agencies	DSWs who are not already insured through a spouse or public insurance program. Monthly cash contributions to personal accounts are 50 percent less (\$30) for workers who work 29 hours per week or less.	Small businesses (2-50 employees), self-employed, sole proprietors, and uninsured individuals, hours eligibility determined by each employer (must be an average of at least 20 hours per week).	IPs who work at least 86 hours per month for three consecutive months and are who are not eligible to receive other health care benefits. BHP also has income eligibility requirements.
<b># Direct Care Workers Enrolled / Covered</b>	91 of the 239 DSPs who elected to receive the \$50 payment use it to reduce their share of their employer sponsored health insurance plan's premium. The others use the money to reduce or cover the cost of other options under their cafeteria plan. <sup>1</sup>	187	None (difficulty identifying employees to participate due to waiting periods, other coverage)	249	Not available	4,641 (4,091 in the Trust Plan, 550 in the BHP)

## Health Insurance Coverage Initiatives for the CMS Direct Service Workforce Demonstration Grants 2003 and 2004

	<b>Indiana</b> Arc Bridges, Inc.	<b>North Carolina</b> Pathways for the Future, Inc.	<b>Virginia</b> Department of Medical Assistance Services	<b>New Mexico</b> Department of Health, Long Term Care Services Division	<b>Maine</b> Governor's Office of Health Policy and Finance	<b>Washington</b> Home Care Quality Authority
<b>Benefits</b>	Comprehensive benefit plan, including preventive care, prescription drugs, and mental health services.	Range from major medical (comprehensive coverage) to mini medical (limited reimbursement for limited benefits) depending on which plans the four participating agencies offer and which the workers choose.	Potentially modeled after state of Virginia Blue Cross plan.	Basic health insurance offers limited reimbursement (less than rates charged by providers) for certain health care events; drug card provides 10% or greater discounts on prescriptions and other medical equipment needs. Full-time workers receive \$60 per month to be deposited in a monthly cash benefit account to pay for allowable medical expenses not covered by the basic health care insurance or the perscription benefit. No deductible but also no catastrophic coverage.	Comprehensive benefits package including preventive care, prescription drugs, and mental health services.	Both plans offer a comprehensive benefits package that includes prescription drugs, preventive care, and mental health services. Only Trust Plan includes dental and vision; only BHP is open to family coverage.
<b>Administration</b>	Private insurance - Anthem Blue Cross Blue Shield	Private insurance - several different carriers	Private insurance	All three components are private insurance products. Workers must pay up front for medical expenses and then submit claims to the basic health insurance plan. Workers receive an immediate discount with their drug card but must pay up front for the cost of prescriptions that exceed the discount. Workers do not own their personal accounts and there are no carry over provisions. Funds left over at the end of each plan year revert to the project (grantee).	Public-private partnership between state of Maine and Anthem Blue Cross/Blue Shield of Maine	The Trust Plans are private plans administered by Premera Blue Cross or Kaiser Permanente; BHP is a Public-Private Partnership between Washington State / Kaiser Foundation Health Plan of the Northwest and other regional providers.

## Health Insurance Coverage Initiatives for the CMS Direct Service Workforce Demonstration Grants 2003 and 2004

	<b>Indiana</b> Arc Bridges, Inc.	<b>North Carolina</b> Pathways for the Future, Inc.	<b>Virginia</b> Department of Medical Assistance Services	<b>New Mexico</b> Department of Health, Long Term Care Services Division	<b>Maine</b> Governor's Office of Health Policy and Finance	<b>Washington</b> Home Care Quality Authority
<b>Total Premium Costs</b>	High. Range from \$367 to \$543 per member per month depending on the size of the deductible.	Varies. Ranges from \$132.68 per employee per month for the mini-medical insurance to between \$142 and \$419 and as high as \$585 per member per month for major medical plans, depending on the level of coverage that agencies offer and employees choose.	Not yet determined	Low. Together, the three components cost \$111 per month per person (basic insurance plan \$40, prescription card \$5, cash contribution to accounts \$60, plus \$6 admin fee for account provider).	Medium. Range from \$313 to 338 per member per month.	Medium. Range from \$237 per member per month (BHP) to \$497 (Trust Plan).
<b>Cost to Employees</b>	High. Employees pay 50% the cost of the premiums, which after the \$50 benefit is applied range from \$133 to \$222 per member per month (higher for spouse and family coverage). Employees also pay co-pays and deductibles. Some employee costs can be reduced by other cafeteria plan benefits.	Varies. Ranges from no premium costs for direct care workers who choose mini medical or other plans that require an employee contribution that is less than the subsidy (\$108) to greater amounts for employees who choose plans that require an employee premium greater than the subsidy. The subsidy cannot be used to cover the cost of co-pays and deductibles.	Not applicable	Varies. Workers pay no monthly premiums but they do face significant although reimbursable up-front expenditures. Workers carry the risk of very high costs if they have medical expenses that exceed the amount of money accrued to their accounts.	Varies - Employees pay from 0 to 40% of the monthly premium plus co-pays and a deductible. Discounts based on income and family size reduce both monthly premiums and maximum out of pocket costs by 20 to 100%. No out of pocket costs for those at or below 200% of the federal poverty level (\$17,960 for an individual; \$36,800 for a family of four).	Low. \$17 per month premium, plus modest co-pays, \$150 deductibles and 20% co-insurance with some variation by plan.
<b>Cost to Employers</b>	Medium. Employers pay 50% of the cost of the premiums, which range from \$183 to \$272 per member per month.	Varies. In the range of \$120 per member per month for agencies offering mini-medical plans and higher for agencies offering comprehensive plans, depending on what level of employee contribution they require.	None. Original intent was to fully subsidize employer share.	None. There is currently no cost to employers.	Medium. Employers pay 60% of the cost of monthly premiums or in the range of \$188 - \$203 per member per month.	High. The state, the employer of record for the purposes of collective bargaining, pays \$500 per employee per month. <sup>3</sup>
<b>Cost to Other payers</b>	CMS grant covers 100% of the \$50 per member per month cafeteria benefit.	CMS grant covers 100% of the \$108 per member per month subsidy.	Original intent was for CMS to pay 100% in year 1, 67 percent in year 2, and 33 percent in year 3.	CMS grant covers 100% of the total cost of \$111 per member per month.	<u>Outreach:</u> CMS pays for 100% of the outreach program to the 26 agencies. <u>Coverage:</u> The state of Maine, through the Dirigo program, pays for the discounts on employee costs, or up to 40% of the cost of the premiums.	<u>Outreach:</u> CMS grant pays for 100% of the outreach work carried out through the RWRCs. <u>Coverage:</u> As noted under <i>Costs to Employers</i> , all insurance costs except the \$17 worker contribution are covered by the state.

## Health Insurance Coverage Initiatives for the CMS Direct Service Workforce Demonstration Grants 2003 and 2004

	<b>Indiana</b> Arc Bridges, Inc.	<b>North Carolina</b> Pathways for the Future, Inc.	<b>Virginia</b> Department of Medical Assistance Services	<b>New Mexico</b> Department of Health, Long Term Care Services Division	<b>Maine</b> Governor's Office of Health Policy and Finance	<b>Washington</b> Home Care Quality Authority
<b>Outreach</b>	Individual meetings with workers; written communications.	No uniform plan for outreach. Partners meet each month to brainstorm. Grantee provides an information template that can be formatted and individualized by each agency. Agencies are using newsletters, staff meetings and announcements with paychecks.	Limited outreach: identified employers through existing state relationships.	Individual meetings with workers, on-going staff meetings and written communications.	Outreach targets agencies, rather than workers directly. Grantee is partnering with a non-profit organization in Maine that works to increase access to affordable health coverage to provide information to employers individually, through group meetings and written materials. Have established a 1-800 hotline to answer questions about this plan and other coverage options.	The union, SEIU 775, and the Trust distribute information and enrollment forms to all newly eligible workers. In addition, four RWRCs managed by the Health Care Quality Authority provide written and verbal information about the plans, explain options and help workers fill out applications. <sup>4</sup>
<b>Sustainability of Insurance Coverage</b>	Uncertain. The agency is looking for funding so that they can continue the \$50 cafeteria benefit.	Uncertain. Securing state funding to sustain the subsidies will be difficult. The larger agencies may have sufficient resources to continue the subsidies themselves (and keep employee premium costs at these levels).	State is refocusing - considering focus groups with employees; survey of employers; and identifying potential insurance plans.	Uncertain. It may be possible to continue the arrangement if provider agencies and DSWs both contribute to the cost.	Certain for now. The program is new and controversial. However, it is strongly supported by the Governor who is running for re-election. As long as the political climate doesn't change dramatically Dirigo will likely continue but may be redesigned.	Certain. Strong political support and union advocacy assure continuation of health coverage although form of coverage could change.
<b>Grantee Contact Information</b>	Debra Irving-Holley 219-985-6549 DIrving@arcbridges.com	Linda Kendall Fields 828-712-4003 lkfields@mindspring.com	Teja Stokes 804-786-0527 teja.stokes@dmas.virginia.gov	Barbara Ibanez 505-272-6271 bibanez@salud.unm.edu	Elise Scala 207-228-8423 elise.scala@usm.maine.edu	Mindy Schaffner 360-725-2635 mschaffner@hcqa.wa.gov

### Endnotes:

1. Cafeteria options include: vision coverage, dental coverage, accident insurance, hospital confinement indemnity insurance, cancer
2. Statewide, there is a total of 26,000 IPs and 35% of this workforce or 9,100 IPs are potentially eligible for health coverage based on the number of hours they work.
3. Medicaid consumer-employers have a statutory right to recruit, hire, supervise and terminate their own IPs but do not have any responsibility for paying for their health care coverage.
4. Trust application is simple 1-page paper application. BHP application is 7 pages.

---

## Acknowledgements

This report was prepared by Tameshia Bridges, MSW, Senior Health Policy Analyst for the Paraprofessional Healthcare Institute (PHI) Health Care for Health Care Workers (HCHCW) initiative in Michigan; Hollis Turnham, PHI's Michigan Policy Director; and Carol Regan, Director of the HCHCW initiative. Dorie Seavey, National Policy Specialist for PHI, provided assistance in data analysis.

Data analyzed for this report was collected through a telephone survey commissioned by the Michigan Quality Home Care Coalition ([www.mihomecare.org/coalition](http://www.mihomecare.org/coalition)), a coalition of all who care about the quality of in-home care, including senior citizen advocacy groups, disability rights associations, home care providers, family members, community groups, religious leaders, and elected officials.

The telephone survey was conducted by the Feldman Group Inc. of Washington, D.C.

---

*To order copies of this and other PHI publications, send your request to:*

**National Clearinghouse on the Direct Care Workforce**

349 East 149th Street, 10th Floor  
Bronx, NY 10451  
Phone: 718-402-4138 • Toll-free: 866-402-4138  
Fax: 718-585-6852  
E-mail: [info@directcareclearinghouse.org](mailto:info@directcareclearinghouse.org)

*This publication is also available on the web at:*

[www.coverageiscritical.org](http://www.coverageiscritical.org)  
[www.directcareclearinghouse.org](http://www.directcareclearinghouse.org)  
[www.paraprofessional.org](http://www.paraprofessional.org)

**In Michigan contact:**

Paraprofessional Healthcare Institute  
1325 S. Washington Avenue  
Lansing, MI 48910  
Phone: 517-372-8310 • Fax: 517-372-8317

Hollis Turnham, Michigan Policy Director  
Direct: 517-327-0331  
[hollis@paraprofessional.org](mailto:hollis@paraprofessional.org)

Tameshia Bridges, Michigan Senior Research Analyst  
Direct: 517-372-8310  
[tbridges@paraprofessional.org](mailto:tbridges@paraprofessional.org)

Maureen Sheahan, Michigan Practice Specialist  
Direct: 248-376-5701  
[msheahan@paraprofessional.org](mailto:msheahan@paraprofessional.org)

---

## The Paraprofessional Healthcare Institute

PHI works to improve the lives of people who need home or residential care—and of the workers who provide that care. Our practical workplace and policy expertise helps consumers, workers, and employers improve care by improving the quality of direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers so both may live with dignity, respect, and independence.

PHI's program activities include developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. PHI also staffs the National Clearinghouse on the Direct Care Workforce ([www.directcareclearinghouse.org](http://www.directcareclearinghouse.org)), a central online library of news, research, best practices, and other information for people working to solve the direct-care staffing crisis in long-term care.

**Health Care for Health Care Workers** ([www.coverageiscritical.org](http://www.coverageiscritical.org)), an initiative of PHI, seeks to expand health coverage for workers who provide support and assistance to elders and people living with chronic illnesses and/or disabilities. Consumers need a skilled, reliable, and stable direct-care workforce to provide quality long-term care services. We believe that one way to ensure a quality direct-care workforce is to provide quality direct-care jobs—jobs that offer health coverage and pay a family self-sufficient wage.

## Executive Summary

*When Michigan's Caregivers Lack Coverage* identifies a significant challenge facing Michigan's health, aging, and disability services: high rates of uninsurance among direct-care providers\* employed by the Michigan Medicaid Home Help Program. As is detailed in this report, this predominately female, older, and overwhelmingly low-income workforce faces not only high rates of uninsurance but also significant financial burdens associated with accessing health care services.

Michigan's Home Help Program is the state's largest Medicaid-funded long-term care program providing personal care services to elderly and disabled adults who otherwise could not live independently. To qualify for services, Home Help clients must have very low incomes—50 percent below the federal poverty level (\$4,400/year for a single person)—or have medical bills that far outstrip their ability to pay. Despite such restrictive eligibility rules, the program serves over 55,000 people annually.

The Home Help program provides personal care services to some of Michigan's poorest residents, and the providers it employs to support these individuals live in poverty or near poverty as well. During the time of the telephone survey that provided data for this report, almost half of the 45,000-person workforce earned as little as \$5.15 hour. Accordingly, one of every six providers lived in a household with an annual income below \$10,000.†

As a workforce hired directly by consumers, Home Help providers do not receive employment-based health coverage. Many, because of their extremely low wages, rely on publicly funded health insurance and safety-net services. For those who do not qualify for public programs, however, purchasing private insurance is extremely difficult. As a result, Home Help providers are uninsured at a much higher rate than other Michigan residents.

### Key Findings

- Nearly one-third (29 percent) of Home Help providers lack health insurance coverage. This rate is almost three times the level of uninsurance in Michigan statewide—11 percent of Michigan residents, ages 18 to 64, are uninsured.
- Of the Home Help providers who have insurance coverage, 33 percent are covered from a second job or pay for insurance themselves; over a third rely on public coverage through Medicaid and Medicare.
- Geographic disparities in insurance coverage exist within the state. In some areas, including counties within the greater Kalamazoo, Lansing, Allegan, and Grand Rapids regions, Home Help providers have higher rates of uninsurance than their counterparts in the rest of the state.
- Home Help providers, regardless of insurance status, pay significant out-of-pocket health care expenses. One in six Home Help providers purchases his or her own private health insurance, despite having very low incomes. Nearly half (44 percent) of uninsured providers report having unpaid medical bills. As a result of medical debt, many Home Help providers are saddled with bad credit and higher interest rates.

\*Generally, PHI and others working in the field refer to people working as frontline, non-licensed caregiving staff as direct-care workers. People employed by the Michigan Medicaid Home Help program are titled "providers" by that program and "providers" is the term used in this report to describe members of this workforce.

†In October 2006, nine months after this telephone survey of Home Help providers, the state's wage rate for these jobs increased to a \$7.00 per hour floor in all counties. For those counties already paying more than \$7.00 per hour, the wage increased by \$0.50.

- Uninsured Home Help providers lack a regular source of care. Half of the uninsured providers report not seeing a doctor when it is necessary, including many who report having chronic illnesses such as hypertension or diabetes.

## Implications

Home Help providers—people who provide thousands of Michigan residents with essential health care services—ironically lack adequate and affordable health insurance coverage themselves. Even Home Help providers with health insurance coverage report inadequate coverage, exposing them to significant medical debt. The lack of health care insurance is particularly difficult for the one-third of Home Help providers who live with chronic health problems. However, the impact of high levels of uninsurance and underinsurance does not stop at the doorstep of these providers; it touches the lives of those for whom they provide care and places strain on the long-term care system and the entire health care sector.

Most importantly, inadequate health insurance coverage and care of Home Help providers results in:

- An unhealthy workforce that cannot provide consistent, high-quality care for consumers;
- A diminishing pool of providers willing and able to care for people who are old or living with disabilities at a moment when these populations are increasing exponentially; and
- Increased costs for the publicly funded health care system because providers must rely on public insurance systems, emergency rooms, and neighborhood health care clinics.

The lack of insurance for Home Help providers can leave consumers without reliable and consistent care. When Home Help providers become ill—or have to manage chronic health conditions without adequate medical care for themselves—they miss work, or end up unable to do the work at all. This is highly disruptive to consumers who rely on their Home Help providers for the support they need to live independently.

Also, the number of consumers needing long-term care is growing, yet incentives for people to become direct-care workers are few. As demand for direct-care providers continues to grow, health insurance coverage is essential to attracting and retaining a qualified and committed direct-care workforce.

---

## I. Introduction

The Michigan Medicaid Home Help Program provides personal care services to over 55,000 elders and individuals with disabilities who need long-term care services and supports. Over 45,000 direct-care providers support eligible consumers by providing personal care services (e.g., bathing and toileting) and doing daily chores (e.g., grocery shopping, meal preparation, and laundry).

Most Home Help providers are different from other direct-care workers who provide Medicaid-funded long-term care services because they are considered “independent providers”—i.e., they are hired directly by the consumers for whom they provide care rather than by an agency. As “independent providers,” Home Help providers’ wages, benefits, and training needs are often overlooked. In 2005, the Michigan Quality Community Care Council was created to provide a centralized entity to monitor the administrative, support, and training needs of Home Help providers, as well as establish a registry where consumers can access available providers.

In an effort to better understand the needs of this workforce, the Michigan Quality Home Care Campaign commissioned a telephone survey to assess provider satisfaction, wages, and health insurance availability. The Paraprofessional Healthcare Institute (PHI) analyzed the health insurance findings from the survey as a part of its Health Care for Health Care Workers (HCHCW) initiative. The findings from this survey provide important information on the lack of adequate and affordable health insurance coverage for Home Help providers and how it impacts their lives, Michigan’s vital long-term care system, and the larger health care industry.

## II. Survey Methodology and Data Sources

The *Michigan Homecare Workers’ Survey* was designed by the Feldman Group, Inc., with assistance from PHI on the health insurance portion of the survey instrument. The Feldman Group administered the survey via telephone interviews from December 11, 2005, to December 15, 2005. Participants were contacted both during the day and in the evening.

The survey sample is a random sample of Michigan Home Help providers. Respondents were screened for current or recent employment in the program from a Home Help provider list supplied by the state of Michigan. The telephone survey gathered data on the demographic and employment characteristics of the workforce; their experience in the program; health and health insurance status; access to care and use of health services. A total of 600 telephone interviews were completed.

In addition, background information on the Home Help Program and county wage rates were provided by the Michigan Department of Community Health (DCH) and the Michigan Department of Human Services (DHS). Information on the assessment process and services provided in the Home Help Program are from relevant sections of the DHS Adult Services Manual.

---

### III. The Michigan Home Help Program

The Michigan Medicaid Home Help Program provides personal care services to elders and individuals living with disabilities. These 55,000 Medicaid recipients account for half of the beneficiaries receiving Medicaid long-term care services in Michigan but their services compromise only 12 percent of the state’s long-term care expenditures. The current annual cost of the program, \$206 million, is funded entirely with state (\$86.52 million) and federal (\$119.48 million) monies.

The Home Help Program enables consumers to live independently at home. It is a “consumer-directed” long-term care program that allows consumers to directly supervise providers and

---

***The 55,000 Home Help recipients account for half of the beneficiaries receiving Medicaid long-term care services.***

---

manage delivery of authorized services. Home Help consumers have the right to recruit, select, and train their own providers. The provider and consumer jointly report delivered services to DHS. A DHS caseworker also is required to meet twice a year with both the consumer and the Home Help provider.

Consumer eligibility for Home Help is based on income; consumers must have an annual income of less than \$4,400 or spend down to that income level by incurring medical expenses. Once deemed financially eligible, consumers are then assessed by local DHS staff as to the kinds of personal care services needed and the amount of hours needed for each service.

Home Help services are delivered in consumers’ homes, with monthly hourly caps on house-cleaning (8 hours), laundry (7 hours), shopping for food and other necessities of daily living (5 hours), and meal preparation (25 hours). The average Home Help consumer receives 55 hours of service per month, encompassing assistance with both activities of daily living (ADL) and instrumental activities of daily living (IADL).<sup>1</sup> Approximately 24,000 Home Help consumers need levels of service that qualify them to live in nursing homes.<sup>2</sup>

---

## IV. Survey Findings and Analysis

### General Demographic Information

Based on the survey’s demographic information outlined in **Appendix 1**, the Michigan Home Help workforce is predominately female (83 percent); tends to be middle-aged or older (74 percent are over age 45 and 22 percent are over age 65); and is racially and ethnically diverse (50 percent white, 38 percent African American and 6 percent Latino). These home care providers are likely to be poor or near poor, with *over half* reporting annual household incomes of \$30,000 or less and 15 percent below \$10,000. Nearly half are married (43 percent) and one-quarter (26 percent) live in households with children under 19. Over one-third have a chronic health condition such as diabetes, asthma, or high blood pressure.

The profile of the state’s Home Help workforce differs from that of other direct-care workers employed by nursing homes and home health agencies in Michigan (**Table 1**).<sup>3</sup> Home Help providers are more likely to be African-American (38 percent) than other direct-care workers (23 percent) in the state. Home Help providers are less likely than other direct-care workers to be married (43 percent as compared to 51 percent) or to live in a household with a minor child (26 percent live in households with a child under 19 as compared to 49 percent of other direct-care workers).

---

**Table 1**

#### ***Home Help Provider Demographics Compared to Those of Other Direct-Care Workers (Employed by Nursing Homes or Home Care Agencies)***

<b>Characteristic</b>	<b>Home Help Provider</b>	<b>Other Direct-Care Workers</b>
African-American Workers	38%	23%
Married Workers	43%	51%
Workers with Children Under 19	26%	49%

---

### Employment Characteristics

The data in **Appendix 2** reflects Home Help providers’ longevity, satisfaction, and commitment to their work. For 68 percent of providers, the Home Help program is their only employment. Over one-third (38 percent) work part-time and 31 percent work more than 40 hours per week. The majority (80 percent) of Home Help providers have only one client. Most of these providers are committed to their jobs and their clients, with one-third having been Home Help providers for between two and five years, and 39 percent with more than five years of service.

Even with the high level of commitment that providers have to their work, there is still considerable turnover among Home Help providers. A survey of Home Help consumers showed that about one-third (35 percent) had a provider change within the year.<sup>4</sup> The most common reason reported for the change was that the provider “got a different job.”

Notably, more than half of Home Help providers care for a relative, a factor that likely contributes to longevity. Across the country, the practice of hiring a family member to provide Home Help services is relatively common in consumer-directed state Medicaid programs. A recent national study of 40 states operating 62 consumer-directed programs found that 79 percent of the programs allow family members to be paid caregivers.<sup>5</sup>

Because of the intimate nature of caregiving, many consumers are more comfortable with a family member providing personal care services. In addition, low wages make it difficult to attract other workers. States have used this design element in an effort to stabilize the workforce and provide long-term care services to consumers who do not want to move into nursing homes or other residential care settings.<sup>6</sup>

Michigan’s elderly population is expected to expand by more than 70.7 percent by 2030, and the traditional source of new caregivers, women ages 25 to 44, is projected to shrink by more than 10 percent.<sup>7</sup> As the number of elderly and individuals with disabilities continues to grow, family members will be an important pool of new direct-care workers. A recent study of California’s Medicaid-funded In-Home Supports Services (IHSS) workers—that state’s Home Help providers—shows that paying family members to provide homecare services can bring more workers into the direct-care workforce.<sup>8</sup> Of IHSS workers who currently provide care to a family member, 43 percent reported that they would consider continuing to provide care to strangers in the future.

### Wages and Benefits

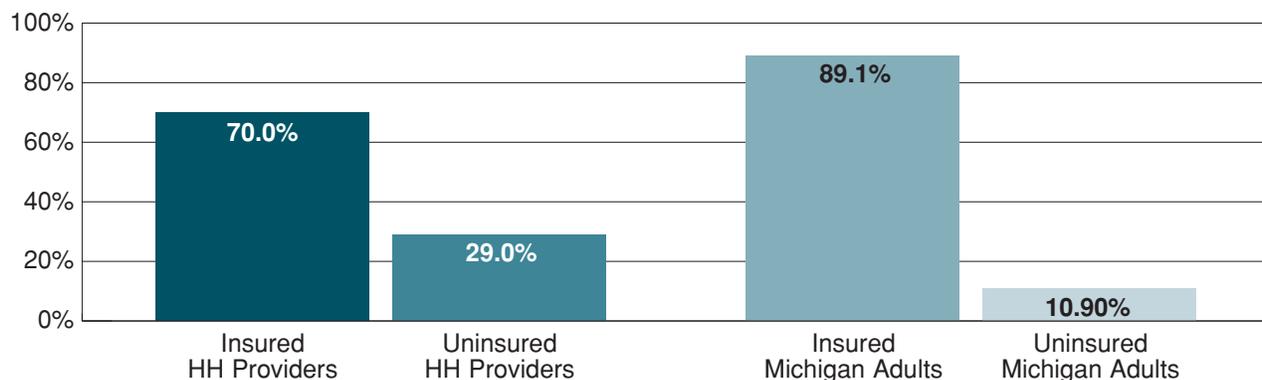
Increased appropriations allowed the wage rate for Home Help providers to increase to a floor of \$7.00 per hour in October 2006. For those county wage rates already set at more than \$7.00/hour, the wage increased by \$0.50 per hour. This is the first wage increase Home Help providers have had in about a decade.<sup>9</sup>

Historically, Home Help provider wage rates were set by each county’s Family Independence Agency boards, now the county DHS. As a result, wages vary from county to county. Prior to this October 2006 increase, the average wage for Home Help providers was \$6.07 per hour, but almost half of the 45,000 person workforce earned as little as \$5.15 per hour. While this increase is significant, these providers still earn wages that are significantly less than the overall average of \$19.25 per hour for all Michigan workers.<sup>10</sup>

In addition, survey results indicate that nearly one-third (29 percent) of Home Help providers lack health insurance coverage. This rate is almost three times the overall level of uninsurance in Michigan—10.9 percent of Michigan residents, ages 18 to 64, are uninsured (**Chart 1**).<sup>11</sup>

**Chart 1**

### *Insurance Status of Home Help Providers Compared to Michigan Population*

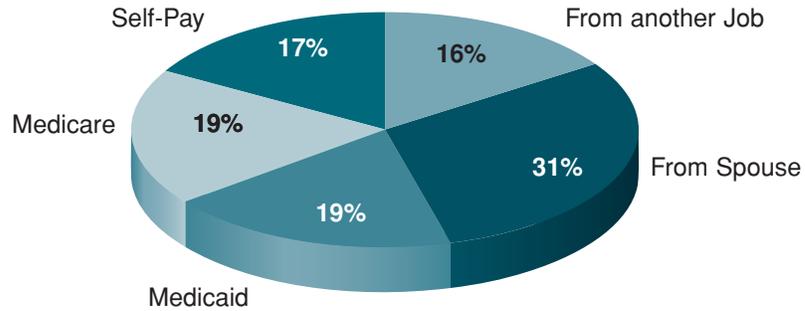


Of Home Help providers who are insured, survey results show that 31 percent receive their health care coverage from their spouse, and another 33 percent either get it from another job or

purchase private insurance themselves. Of those with insurance, 19 percent have Medicaid coverage and 19 percent are covered by Medicare (with some reporting dual eligibility).

**Chart 2**

***Source of Coverage for Insured Home Help Providers<sup>12</sup>***



**Insurance Status: Key Findings**

**The high level of uninsurance among Home Help providers is directly related to their wages and family income levels.**

Home Help providers earn wages that are significantly lower than those of other direct-care workers in the state’s long-term care system and Michigan residents overall. According to the U.S. Bureau of Labor Statistics,<sup>13</sup> organizational-based direct-care workers (nursing aides and home health aides) in Michigan earn a median hourly wage of \$10.13; overall the average wage for all Michigan workers is \$19.25/hour.

As a result of their low wages, Home Help providers’ households are generally poorer than those of other direct-care worker households and households in Michigan overall. Of Home Help providers, 56 percent report living in households with incomes under \$30,000. Of all households in Michigan, 38.9 percent have incomes below \$30,000.<sup>14</sup> Another indication of the relative poverty experienced by Home Help providers is high rates of public assistance: one-third of survey respondents receive some type of public assistance.<sup>15</sup>

As national studies show, the working poor—i.e., those with low paying jobs like Home Help providers—are least likely among all Americans to have health insurance coverage.

Nationally, poor people (defined as those with incomes below 100 percent of the federal poverty level [FPL]) are twice as likely to be uninsured as the population overall. Two-thirds of the uninsured nationally are families with incomes less than 200 percent of FPL. Findings from a recent telephone survey of Michigan households showed that households with incomes between \$10,000 and \$20,000 had the highest levels of uninsurance (26 percent) across all income categories.<sup>16</sup>

Given these figures, it is not surprising that Home Help providers have an uninsurance rate that is almost three times higher than the state average. The working poor have the greatest difficulty accessing health insurance because their employers don’t cover them, many are ineligible for public programs, and they cannot afford to buy coverage. Of Home Help providers with annual household incomes between \$10,000 and \$20,000, 42 percent lack health insurance.

**Table 2**

***Health Insurance Status of Home Help Providers by Household Income***

<b>Household Income</b>	<b>Insured</b>	<b>Uninsured</b>
Under \$10K	61%	29%
\$10K–\$20K	58%	42%
\$20K–\$30K	67%	33%
Over \$30K	85%	15%

The rate of insurance coverage for the poorest Home Help providers (those with household incomes below \$10,000) is slightly higher than those in the \$10-\$20,000 category because these poorest providers are more likely to be covered by public insurance programs.

**All Home Help providers, regardless of insurance status, have significant out-of-pocket health care expenses and medical debt.**

Despite low Home Help wage rates and poverty-level household income, nearly one in six Home Help providers (17 percent) pays out-of-pocket for his or her own private health insurance, indicating the high value providers place on health insurance despite having little disposable income. Not surprisingly, these providers report both high premium levels and out-of-pocket costs. Of Home Help providers buying private health coverage, 69 percent report paying the full cost of their plan, with almost half (45 percent) paying \$50 to \$200 per month in premiums and 37 percent paying more than \$200 per month. Yet 36 percent of Home Help providers with private health insurance also report having over \$1,000 in out-of-pocket medical expenses not covered by health insurance.

These costs add up. Of Home Help providers with private insurance, 25 percent report unpaid medical bills, as do 23 percent of those covered by Medicare. Home Help providers without health insurance are even more likely to have medical debt. Nearly half (40 percent) of uninsured Home Help providers report unpaid medical bills as a current financial burden.

**Uninsured Home Help providers are less likely to see a doctor for needed care.**

More than half of uninsured Home Help providers (52 percent) report not seeing a doctor for necessary care. This inability to access health services is higher among Home Help providers than other uninsured adults in Michigan: 43 percent of all uninsured adults in Michigan report not seeing a doctor for necessary care.<sup>17</sup> This lack of access to health services is particularly disturbing considering that one-third of Home Help providers report having a chronic illness—e.g., hypertension or diabetes. These types of diseases are best managed with regular health care. Study after study shows that people without health insurance delay care, experience greater declines in health status, and die sooner than adults with continuous coverage.<sup>18</sup>

**Home Help providers rely heavily on publicly funded health care sources.**

Over one-third of insured Home Help providers receive their coverage through public insurance programs—either Medicaid (19 percent) or Medicare (19 percent). In addition to public funds used to cover Home Help providers through Medicaid or Medicare, as shown in **Table 3**, nearly half of uninsured providers report using hospital emergency rooms and community clinics, which rely heavily on public funding, to access health services.

**Table 3**

**Source of Care for Home Help Providers**

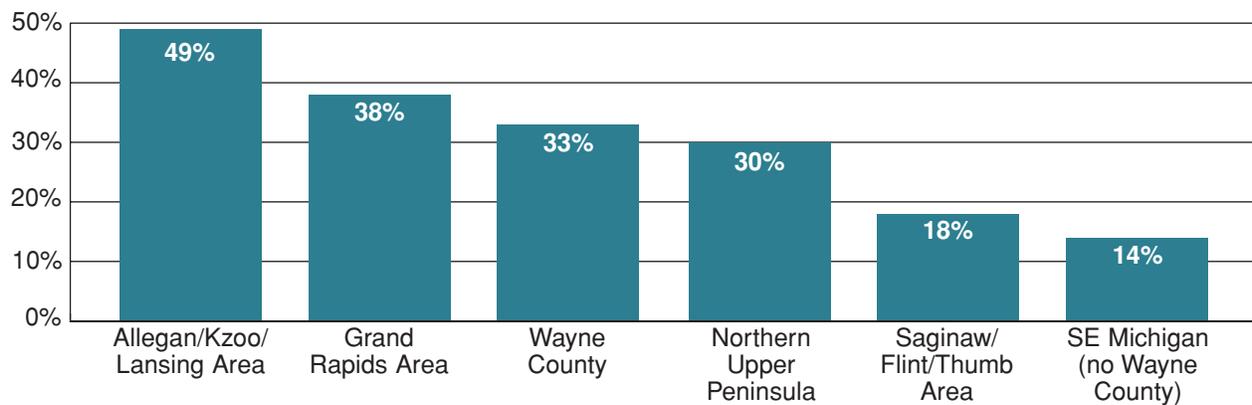
Source	Overall	Insured	Uninsured
Hospital Emergency Room	11%	7%	22%
Doctor's Office	68%	77%	48%
Local Community Clinic	17%	14%	25%

**Geographic disparities exist in health insurance coverage in Michigan**

Home Help providers in the Grand Rapids area and the Allegan/Kalamazoo/Lansing area are more likely to be uninsured—38 percent and 49 percent, respectively—than those living in other regions of the state. The high rates of uninsurance reflect higher percentages of households in these regions with annual incomes under \$20,000.<sup>19</sup>

**Chart 3**

**Rates of Home Help Provider Uninsurance by Michigan's Geographic Regions**



**Single Home Help providers are more likely to be uninsured than married providers.**

Over one third (37 percent) of single providers lack health insurance coverage compared to providers who are married (20 percent), reflecting the extent to which many providers rely on their spouse for health insurance coverage. This is consistent with national data showing that individuals who have never been married comprise 45 percent of the uninsured.<sup>20</sup>

**African-American Home Help providers are more likely to be uninsured than other racial groups.**

One-third of African American providers are uninsured compared to one-quarter of white Home Help providers. Disparities exist between low-income households as well, with African-American Home Help providers in households with incomes of less than \$20,000 annually more likely to be uninsured (43 percent) than white providers (35 percent) with the same household incomes.

## V. Implications

### Implications for Providers

Findings in this report show that Home Help providers' lack of adequate and affordable health insurance coverage affects their health and their economic security. Nearly one-third are uninsured and cannot afford the cost of medical care. In addition, many of those who are insured report being burdened with high out-of-pocket expenses. Uninsured and underinsured Home Help providers report delaying needed medical care because they cannot afford to pay for it.

When they can no longer delay medical care, uninsured and underinsured Home Help providers often seek care through safety-net providers rather than a family doctor. This means they are less likely to receive quality health care services in a consistent manner, and may not be screened for treatable conditions such as diabetes, cancer, and cardiovascular diseases. The result is later diagnoses at more costly stages of the disease and shorter lengths of survival.<sup>21</sup> A recent study confirms these conclusions: of uninsured individuals with a chronic illness such as diabetes, 59 percent did not fill a prescription or missed a dose of medication because they could not afford it.<sup>22</sup> Taking medication as prescribed and seeing a physician for necessary care are positive health behaviors that can save lives and money.

This same study found that:

- More than one-third of uninsured individuals with a chronic illness recently went to an emergency room or had an overnight hospital stay, a level of hospitalization two times higher than that of insured individuals with a chronic disease.
- Uninsured individuals are less likely to get pap or colon cancer screenings or mammograms.
- Uninsured individuals are twice as likely to have duplicative tests ordered.

Although uninsured individuals are likely to access care through safety-net providers—community clinics, community health centers, and hospital emergency rooms—these services are not free. The average emergency room visit costs \$560.<sup>23</sup> For low-income individuals without health insurance, this type of medical expense may take months, if not years, to pay off.

Thus, many Home Help providers must cope with the financial strain of medical debt. These costs can compromise their ability to afford basic necessities, or in the worst case scenario, place them in jeopardy of medical bankruptcy. A 2000 study found that almost half of the 7,000 uninsured individuals surveyed had medical debt from a safety-net provider.<sup>24</sup> This same survey found that, particularly in rural areas, the stigma and shame associated with having an unpaid medical bill deters individuals from returning to the same health care provider.

The financial consequences for underinsured individuals are equally dire. One out of six of those surveyed in a study released last year indicated that their credit scores had been harmed by medical debt of less than \$500.<sup>25</sup> The stigma of medical debt also affects underinsured individuals, leading to delays in care for themselves or their families, and as a result, poor health outcomes.<sup>26</sup>

## Implications for Long-Term Care Consumers

Michigan is facing a shortage of direct-care workers. Michigan’s elderly population will more than double over the next 25 years, but the state’s traditional source of caregivers—women ages 25 to 44—is projected to shrink by more than 10 percent. Given this crisis, it is important to begin identifying and implementing measures to attract and retain qualified and committed direct-care workers. Employment in the long-term care sector that does not offer adequate and affordable health insurance coverage diminishes the sector’s ability to attract people to this field. In several Michigan and national studies, direct-care workers say that lack of health insurance coverage is one of the factors that contributes to their dissatisfaction with their jobs and their decision to seek other employment.<sup>27, 28, 29</sup> High vacancy and turnover rates directly impact the quality of care available to consumers, who need skilled, consistent, and compassionate caregivers to support them.<sup>30, 31, 32</sup>

Not enough providers is only one issue affecting consumers. The quality of long-term care also depends on healthy providers; yet as has been documented in this report, many Home Help providers—who make up more than one-third of the state’s approximately 120,000 direct-care workers—lack a key ingredient in living healthy lives: adequate and accessible health insurance coverage.

When Home Help providers lack health insurance coverage, long-term care consumers and their families are the first to feel the effects. Because caregiving is intimate by nature, it is done best through high-quality, consistent relationships that have been established over time. When providers miss work due to injury or illnesses, the stability of these relationships is compromised and so is the quality of care delivered. A temporary replacement provider does not know the consumer’s preferences for how care is delivered, nor is the consumer necessarily as comfortable receiving care from the replacement caregiver. But the consumer’s care is also placed at risk when providers come to work sick.

This type of instability directly impacts the lives of long-term care consumers—it means they may not be bathed for the day, may not receive assistance with important exercises, or may miss work themselves because their caregiver could not make it to work. Family members also suffer the consequences, often taking time from their own jobs to provide services when a Home Help provider is absent.

## Implications for the Health Care Industry

As a segment of the working poor, Michigan’s uninsured and underinsured Home Help providers are contributing to increased health care costs within the state. As the survey shows, large numbers of these providers access health care through safety-net providers and the Medicaid system because no other options are available.

As these and other low-income workers turn to the health care safety net—i.e., hospitals, community health centers, and community clinics—to access care, that safety net is facing unprecedented financial strain. In 2002, the Citizens Research Council of Michigan reported that Michigan hospitals collectively reported \$1.1 billion in charges for uninsured and uncompensated care in 2000.<sup>33</sup> Although the majority of these charges were in southeast Michigan, west Michigan had the third highest level of uncompensated medical care in the state at approximately \$119 million.

---

More recent reports across the state show that medical systems are facing record levels of uncompensated care. In 2005, Spectrum Health System, the largest provider of care to uninsured and underinsured in west Michigan, reported a 10 percent increase in what it refers to as its “community benefit contribution.”<sup>34</sup> In March 2006, the *Detroit News* reported that hospitals in Metro Detroit had approximately \$740 million in unpaid medical bills in 2005, an increase of \$163 million from 2004. Though low Medicaid reimbursements contributed to this gap in payment, by far the largest portion was the result of poor uninsured and underinsured individuals using emergency rooms as their primary source of care.

Safety-net providers cannot continue to offer adequate care as the number of people without insurance grows and funding shrinks. Federal spending on the safety net increased by 1.3 percent in 2004, while the total number of uninsured Americans grew by 11.2 percent between 2001 and 2004.<sup>35</sup> This pattern inevitably will result in fewer Michigianians having access to adequate health care services. Ironically, among those at risk for losing access to even health care safety-net services are low-income, uninsured, and underinsured Home Help providers who serve the health care system.

## VI. Conclusion

Findings in this report reveal powerful yet all-too-common themes for direct-care workers caring for elderly and disabled consumers. For the majority of providers, the Home Help Program is their only source of employment and with low-wages, they live paycheck to paycheck. Moreover, they are providers in a Medicaid-funded health care program that does not include health insurance coverage for those who care for others.

As a result, many of these providers pay out-of-pocket health care costs that are disproportionate to their income or they delay receiving necessary medical care. They face high levels of medical debt, putting their families further at-risk financially. In addition, they may not receive adequate treatment for chronic conditions, which may leave them unable to continue providing care in the future.

The Michigan Home Help Program is an important part of Michigan’s long-term care system. Services delivered by over 45,000 providers through this program allow tens of thousands of elderly and individuals with disabilities to remain in their homes. Yet, having an uninsured workforce puts these consumers at increased risk. An unhealthy workforce cannot provide the consistent, high-quality services consumers need to remain independent and at home.

Consumers are also put at risk when not enough people are willing to take jobs as caregivers. Michigan’s population is aging and the demand for these services is increasing. Health insurance coverage is critical to attracting and retaining a qualified and committed caregiving workforce that can support our elders in their homes. All Michigan families—those who need care and those who provide care—deserve the security of affordable and adequate health care services.

## Endnotes

1. ADL services include assistance with eating, toileting, bathing, and mobility. IADL services include assistance with taking medication, shopping, housework, and meal preparation.
2. Bachleda, S. (2006). *Michigan's Long-Term Care Populations*. Presentation at the 2006 Michigan Long-Term Care Conference.
3. Comparison data of other direct-care workers in Michigan is from Mickus, M., Luz, C., Hogan, A. (2004). *Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan*. Published by the Michigan Direct Care Workforce Initiative.
4. Michigan Family Independence Agency (2000). *Home Help Services Program: Preliminary Report*.
5. National Association of State Units on Aging. *States' Experiences Implementing Consumer-Directed Home and Community Services: Results of the 2004 Survey of State Administrators, Opinions Survey, and Telephone Interview*. Available at: [www.nasua.org/pdf/20026\\_text.pdf](http://www.nasua.org/pdf/20026_text.pdf) Also, a 2000 study found that nearly half of the consumers in California's In-Home Supports and Services (IHSS) program received care from a relative. See Benjamin, Mathias and Frank (2000). "Comparing Consumer Directed and Agency Models for Providing Supportive Services at Home." *Health Services Research* 35(1), Part II, pp. 351-366.
6. Lagnado, L. (2006). "Seniors in Vermont Are Finding They Can Go Home Again." *The Wall Street Journal*, pp. A1, A12. October 23.
7. National Clearinghouse on the Direct Care Workforce. *Michigan State Activities: Background Information*. Available at: [www.directcareclearinghouse.org/s\\_state\\_det.jsp?action=view&res\\_id=22](http://www.directcareclearinghouse.org/s_state_det.jsp?action=view&res_id=22)
8. Benjamin, A.E. (2006). *Labor Force Expansion Through Retention of Related Caregivers*. Issue Brief No. 7. Washington, DC.: Better Jobs, Better Care.
9. Many providers rely on public programs such as Medicaid, Medicare Part D or other public programs. The impact of the wage increase on income eligibility for public programs should be monitored to determine if providers are able to continue accessing these necessary services.
10. U.S. Bureau of Labor Statistics (BLS). (2005). *Occupational Employment Statistics, May 2005*. Available at: [www.bls.gov/oes/current/oes\\_mi.htm#b31-0000](http://www.bls.gov/oes/current/oes_mi.htm#b31-0000)
11. HRSA State Planning Grant on the Uninsured. *Highlights of the Michigan Household Survey*. Available from the Michigan Department of Community Health by request.
12. The survey allowed multiple responses, and the data show 11% with two sources of coverage. For those respondents who said they were covered by Medicaid, 16% were also covered by Medicare; 16 percent of those reporting Medicare coverage were also covered by Medicaid.
13. U.S. Bureau of Labor Statistics (BLS). See footnote 10.
14. HRSA State Planning Grant on the Uninsured. See footnote 11.
15. Food Stamps and SSI/SSDI are the primary types of public assistance Home Help workers receive.
16. HRSA State Planning Grant on the Uninsured. See footnote 11.

17. State Health Access Data Assistance Center (2006). *The Coverage Gap: A State-by-State Report on Access to Care*. Available at: [www.shadac.umn.edu/img/assets/18528/CTUW2006\\_TheCoverageGap.pdf](http://www.shadac.umn.edu/img/assets/18528/CTUW2006_TheCoverageGap.pdf)
18. Institute of Medicine (2002). *Care without Coverage—Too Little Too Late*. Available at: [http://fermat.nap.edu/html/care\\_without/reportbrief.pdf](http://fermat.nap.edu/html/care_without/reportbrief.pdf)
19. The survey found that 41%, 40% and 44% of Home Help workers in the Grand Rapids area, Allegan, Kalamazoo and Lansing area, and Wayne County respectively live in households with incomes less than \$20,000 annually.
20. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (2004). *Research Note: The Long-Term Uninsured*. Medical Expenditure Panel Survey (MEPS) Available at: <http://aspe.hhs.gov/health/long-term-uninsured04/report.pdf>
21. Hadley, J. (2002). *Sicker and Poorer: The Consequences of Being Uninsured*. The Kaiser Commission on Medicaid and the Uninsured. Available at: [www.kff.org/uninsured/20020510-index.cfm](http://www.kff.org/uninsured/20020510-index.cfm)
22. Collins, S.R., Davis, K., Doty, M.D., Kriss, J.L., Holmgren, A.L. (2006). *Gaps in Health Insurance: An All-American Problem. Findings from the Commonwealth Fund Biennial Health Insurance Survey*. The Commonwealth Fund. Available at: [www.cmwf.org/usr\\_doc/Collins\\_gapshtins\\_920.pdf](http://www.cmwf.org/usr_doc/Collins_gapshtins_920.pdf)
23. Steven Macklin Agency for Healthcare Research and Quality. (2006). *Expenses for a Hospital Emergency Room Visit*. Medical Expenditure Panel Survey, Statistical Brief No. 111. Agency for Healthcare Research and Quality (AHRQ). Available at: [www.meps.ahrq.gov/papers/st111/stat111.pdf](http://www.meps.ahrq.gov/papers/st111/stat111.pdf)
24. Andrulis, D., Duchon, L., Pryor, C., Goodman, N. (2003). *Paying for Health Care When You are Uninsured: How Much Support Does the Safety Net Offer?* Boston, MA: The Access Project. Available at: [www.accessproject.org/paying\\_for\\_healthcare\\_when\\_youre\\_uninsured.pdf](http://www.accessproject.org/paying_for_healthcare_when_youre_uninsured.pdf)
25. Seifert, R. (2005). *Home Sick: How Medical Debt Undermines Financial Security*. Boston, MA: The Access Project. Available at: [www.accessproject.org/adobe/home\\_sick.pdf](http://www.accessproject.org/adobe/home_sick.pdf)
26. Flax, K. & Seifert, R.W. (2006). "Medical Debt, Health Care Access, and Professional Responsibility." *Virtual Mentor: Journal of the American Medical Association*, Vol. 8.
27. Tri-County Office on Aging (2005). *A Labor of Love: Assessing the Status of the Direct Care Workforce in the Tri-County Area*. Available at: [www.tcoa.org/documents/DCWSurveyReportcomplete.pdf](http://www.tcoa.org/documents/DCWSurveyReportcomplete.pdf)
28. Mickus, M., Luz, C., Hogan, A. (2004). *Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan*. Available at: [www.miseniors.net/NR/rdonlyres/EDEDAA1A-4646-4B6C-ACBC-44D666301F06/0/MDCWIVoicesFinalCopy.pdf](http://www.miseniors.net/NR/rdonlyres/EDEDAA1A-4646-4B6C-ACBC-44D666301F06/0/MDCWIVoicesFinalCopy.pdf)
29. Pennsylvania Intra-Governmental Council on Long-Term Care (2001). *In Their Own Words: Pennsylvania's Frontline Workers in Long Term Care*. Available at: [www.directcareclearinghouse.org/download/Penn.pdf](http://www.directcareclearinghouse.org/download/Penn.pdf)
30. Michigan Long-Term Care Task Force. (2005). *Workgroup D: Workforce Development Rationale for Recommendations*. Available at: [www.ihcs.msu.edu/LTC/Reports/Combined\\_D\\_Report.pdf](http://www.ihcs.msu.edu/LTC/Reports/Combined_D_Report.pdf)
31. Turnham, H. & Dawson, S.L. (2003). *Michigan's Care Gap: Our Emerging Direct-Care Workforce Crisis*. Bronx, NY: Paraprofessional Healthcare Institute.

- 
32. New York Association of Homes and Services for the Aging (NYAHSA). (November 2001). *Desperate Times: Labor Shortages in New York's Continuing Care System*. NYAHSA Public Policy Series. Available at [www.directcareclearinghouse.org/download/Desperate.pdf](http://www.directcareclearinghouse.org/download/Desperate.pdf)
33. Citizens Research Council of Michigan (2002). *Health Insurance Coverage and Uninsured/Uncompensated Care in Michigan Hospitals*. CRC Memorandum No. 1061. Available at: [www.crcmich.org/PUBLICAT/2000s/2002/memo1061.pdf](http://www.crcmich.org/PUBLICAT/2000s/2002/memo1061.pdf)
34. Spectrum Health (2005). *Spectrum Health Provides \$88 Million in Community Benefit*. Press Release, October 17, 2005. Available at: <http://heartcenter.spectrum-health.org>
35. Hadley, J., Cravens, M., Coughlin, T., Holahan, J. (2005). *Federal Spending on the Health Care Safety Net from 2001-2004: Has Spending Kept Pace with the Growth in the Uninsured?* Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/uninsured/7425.cfm>

## Appendix 1

### *Demographic Information: Michigan's Home Help Providers*

Characteristics	Percentage of Respondents
<b>Gender</b>	
Female	83%
Male	17%
<b>Age</b>	
Under 45	22%
45 – 54	28%
55 – 64	24%
65 and over	22%
<b>Race &amp; Ethnicity</b>	
White	53%
African American	38%
Latino	6%
<b>Marital Status</b>	
Married	43%
Single	27%
Widowed	14%
Divorced	11%
Separated	2%
<b>Household Size</b>	
One member	19%
Two members	34%
Three or more members	52%
<b>Children under 19</b>	
One	14%
Two	12%
None	71%
<b>Household Income</b>	
Under \$10,000	15%
\$10,000 – \$20,000	22%
\$20,000 – \$30,000	19%
Over \$30,000	21%

## Appendix 2

### *Employment Characteristics: Michigan's Home Help Providers*

Characteristics	Percentage of Respondents
<b>Hours Worked per Month</b>	
Less than 20 hours	38%
Between 20 – 40 hours	31%
Over 40 hours	31%
<b>Relationship to Consumer</b>	
Immediate Family Member	57%
Distant Family Member	10%
Non-Family Member	16%
Unknown	16%
<b>Mean Hours Worked</b>	30.32/week
<b>Additional Employment</b>	
Yes	32%
No	68%
<b>Length of Employment</b>	
0 – 2 years	28%
2 – 5 years	32%
Over 5 years	39%

---

## Appendix 3

---

### *Geographic Designations: Michigan*

<b>Geographic Designation</b>	<b>Counties</b>
SE Michigan	Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, Wayne
Grand Rapids Area	Clinton, Ionia, Kent, Mescota, Muskegon, Montcalm, Newaygo, Oceana, Ottawa
Allegan/Kalamazoo/Lansing Area	Allegan, Barry, Berrien, Branch, Cass, Calhoun, Ingham, Hillsdale, Jackson, Kalamazoo, St. Joseph, Van Buren, Eaton
Northern Michigan/Upper Peninsula	Alcona, Alger, Alpena, Antrim, Arenac, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Delta, Dickinson, Emmet, Gladwin, Gogebic, Grand Traverse, Houghton, Iosco, Iron, Kalkaska, Keweenaw, Lake, Leelanau, Luce, Mackinac, Manistee, Marquette, Mason, Menominee, Missaukee, Montmorency, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Schoolcraft, Wexford
Saginaw/Flint/Thumb Area	Bay, Gratiot, Genesee, Huron, Isabella, Lapeer, Midland, Saginaw, Shiawassee, Sanilac, Tuscola

---



**In Michigan contact:**

Paraprofessional Healthcare Institute  
1325 S. Washington Avenue  
Lansing, MI 48910  
Phone: 517-372-8310  
Fax: 517-372-8317  
[www.coverageiscritical.org](http://www.coverageiscritical.org)



National Office:

349 East 149th Street, 10th Floor  
Bronx, NY 10451  
Phone: 718-402-7766  
Fax: 718-585-6852  
[www.paraprofessional.org](http://www.paraprofessional.org)