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December 1, 2021

The Honorable Thomas Albert, Chair, and
Members of the House Appropriations Committee

Dear Chairman Albert and Committee Members:

AARP Michigan appreciates the opportunity to share our testimony with the Committee today regarding the pressing need and current opportunities for the State of Michigan to make positive, lasting reforms to our state's long-term care system. AARP is a nonprofit, nonpartisan 501(c)(4) organization that advocates on issues that matter most to people age 50 and over, such as access to health care and long-term services and supports. AARP has approximately 1.3 million members in Michigan.

The heartbreaking loss of life in nursing homes due to COVID-19 shed new light on the need to reform our state's long-term care system. Yet even before the pandemic, longstanding concerns with traditional nursing homes have led families to seek alternative options which are unfortunately limited in our state. AARP urges the Legislature to make use of one-time federal funding available to the State of Michigan under the American Rescue Plan Act to meaningfully increase access to home and community-based services and other alternatives to traditional nursing home settings. In particular, we appreciate the Committee's interest in specific proposals to:

- Expand presumptive eligibility for Medicaid home and community-based services,
- Expand access to PACE to parts of the state where PACE is not currently available, and
- Pilot a transformation to single room occupancy as the new norm for nursing home care, building on the "Green House" small house nursing home model.

We are enclosing a copy of our white paper entitled ***Home at Last: The Historic Opportunity to Transform Michigan's Long Term Care System Using One-Time Funding in 2021*** along with a separate document that provides cost estimates for the proposals we set forth in that paper, including the specific proposals mentioned above. These are reforms that are both sorely needed now, and that will pay off in the future as ongoing costs for home and community-based services are significantly lower than costs for care in traditional residential settings.

Thank you for your work on this important topic, and for all you do on behalf of Michigan's older adults. If you have further questions, please feel free to contact our Associate State Director for Government Affairs, Melissa Seifert, at 517-316-6393 or mseifert@aarp.org.

Respectfully,

Paula D. Cunningham
State Director

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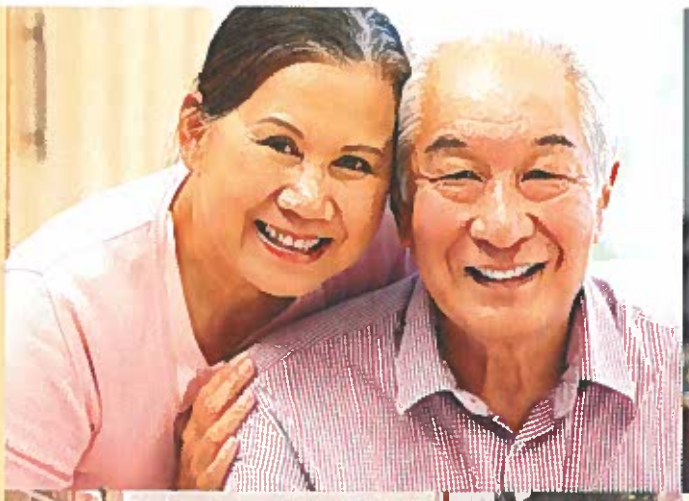


HOME AT LAST

The Historic Opportunity to Transform Michigan's Long Term Care System Using One-Time Funding in 2021

JULY 2021

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HOME AT LAST

This paper describes the need for change in Michigan's long term care system and makes five recommendations for how policymakers can use one-time funding to overcome key structural barriers in the current system. By making these strategic investments, policymakers can rebalance our broken system and allow more Michigan residents to safely *age in place* in the setting nearly everyone prefers: at HOME.

For more information about AARP Michigan's work and any information described in this paper, feel free to contact us.

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AARP Michigan

EXECUTIVE SUMMARY

Michigan's long term care system is in urgent need of transformation, as the COVID-19 pandemic tragically demonstrated.

New one-time federal funds that are available for use from 2021 through 2024 could allow Michigan to achieve two big policy goals that have long eluded our state:

- "Rebalancing" the state's long term care system to allow the majority of Michigan residents to *age in place* in home and community-based settings, rather than in nursing homes, and
- Improving the quality and safety of care provided by nursing homes for individuals who remain in that setting.

Over the past decade Michigan policymakers have pursued and achieved incremental progress toward rebalancing through the annual state appropriations process, and AARP applauds those efforts. However, persistent waiting lists remain for home and community-based care, and comparisons with other states show that Michigan can do better. The pandemic also demonstrated the pressing need for reforms beyond rebalancing, to improve how services are delivered across the continuum of care, including in nursing homes.

Opportunities exist to better align the supply and demand for services, to improve safety, and to make more cost-effective use of the taxpayer dollars spent on long term care. This paper offers policymakers **five recommendations** for using currently available one-time funds to achieve these goals based on best practices already implemented in other states:

1) **Creating statewide HCBS presumptive eligibility**
2) **Expanding assisted/independent senior housing with coordinated supportive services**
3) **Providing HCBS start-up, expansion and innovation funding**
4) **Incentivizing small-house nursing homes (the Green House model)**
5) **Converting traditional nursing homes to 100% single occupancy rooms**

Each of these proposals would incentivize needed structural changes in ways that will make a difference for both the short- and long-term *without creating additional funding obligations for taxpayers when the one-time funds run out.* Investing one-time funds as described in this paper could help our state overcome key challenges in our long term care system that have kept the state locked in a decades-long cycle of spending taxpayer dollars for care in settings that are both *more expensive* than alternatives, and *not* what Michigan residents want for themselves and their families.

AARP looks forward to working with policymakers to further explore, evaluate and implement these proposals to improve quality of life for every Michigander as we age, profoundly and for years to come.

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AARP® Michigan

THE NEED FOR STRUCTURAL CHANGE

The COVID-19 pandemic exposed the dire need to reform Michigan's long term care system.

The heartbreaking loss of life in nursing homes due to COVID-19 and the isolation that left countless others disconnected from loved ones shed new light on the need to reform our state's long term care system. Yet even before the coronavirus pandemic, longstanding problems in traditional nursing homes led individuals and their families to seek alternative options.

Recognizing this reality is not a criticism of the committed and hardworking staff and leadership in Michigan's nursing homes. The problem is with the current *model* of dense congregate care and institutional processes that expose residents not only to significant risks in a pandemic, but also to lower overall quality of life day-to-day.

Research shows most people who need long term care services strongly prefer to remain in their homes. When they need or want to move to receive services, people strongly favor assisted living residences or other home-like settings over nursing facilities. In a survey commissioned by AARP in August 2020, 89% of Michigan residents age 50+ said that if they ever need long term care, they'd prefer to receive that care in their own home, and to avoid ever living in a nursing home.[1]

AARP research going back many years shows that this sentiment is not new. In an extensive survey conducted in 2005 of Michigan voters age 45 and older, 83% of respondents said that it was very important to them that long term care services be available to enable them and family members to remain in their own homes as long as possible should they need long term services and supports (LTSS).

Nevertheless, Michigan continues to rank below many other states in terms of the large proportion of taxpayer dollars we spend to provide institutional care in nursing homes compared to the smaller share of resources that go toward providing long term care for older adults in home and community-based settings (HCBS). Currently, 68.5% of Michigan's Medicaid spending for LTSS goes to pay for care in nursing homes, instead of in people's homes, where they want to be.[2]

In other words, the State of Michigan has continued to spend the majority of taxpayer dollars for LTSS provided in nursing homes, despite data consistently showing that the overwhelming majority of Michigan residents vehemently want to avoid ever living in a nursing home.

This is why AARP Michigan advocates for "rebalancing" our long term care system.

Rebalancing has been a policy goal of AARP and other consumer advocates for decades not only because the overwhelming majority of Michigan residents prefer to "age in place" in their own homes and communities, but also because rebalancing Michigan's long term care system comes at a lower price per person.

"Rebalancing" means delivering more long term services and supports to people in home and community-based settings, instead of requiring most people to be institutionalized in nursing homes to receive these services.

Numerous studies have shown that states that provide a higher proportion of the long term care their residents need through home and community services save money.

In particular, studies show that Medicaid dollars can support nearly three older adults or people with disabilities in home and community-based services for every one person in a nursing home.[3] Statistical modeling found that increasing the portion of Medicaid LTSS dollars toward HCBS by 2 percentage points annually can reduce overall Medicaid LTSS spending by 15 percent over 10 years.[4] This means more people could be served, at lower costs to the state, if our state "rebalances" our long term care system.[5]

AARP's most recent *Long-Term Services and Supports State Scorecard* ranks Michigan at number 30 among all states based on how our state's LTSS system rates across 5 dimensions: *Affordability & Access* (Michigan ranks 30), *Choice of Setting & Provider* (Michigan ranks 24), *Quality of Life & Quality of Care* (Michigan ranks 43), *Support for Family Caregivers* (Michigan ranks 23), and *Effective Transitions* (Michigan ranks 27).[6] The data used to compile the 2020 *Scorecard* were collected and analyzed in 2019, which means the *Scorecard* paints a picture of LTSS system performance from before the coronavirus outbreak began. However, the data and comparisons that the Scorecard make provide useful information about evidence-based solutions and how states with different approaches to long term care service delivery have fared.

A variety of alternatives exist that allow people to age in place by receiving long term services and supports in home and community-based settings (HCBS), rather than in traditional institutional settings[7]. Programs that provide HCBS in Michigan – with various eligibility requirements, and funded by different combinations of taxpayer dollars – include the MI Choice Medicaid Waiver Program, non-Medicaid services delivered through Michigan's Area Agencies on Aging, Program of All-Inclusive Care for the Elderly (PACE), and MI Health Link.

However, access to those services is limited in Michigan. The supply of long term services and supports that are available in Michigan has been out of balance with consumer demand for years. Nursing homes' occupancy rates have been on the decline, while waiting lists for home and community-based services persist.

Waitlists for HCBS exist in part due to statewide caps on the availability of home and community-based services, such as the number of "slots" in the MI Choice waiver program, or the limited geographic areas in which PACE is offered.

Part of the problem is also due to the current practice in our state budgeting process by which nursing homes receive automatic funding increases, whereas citizens and organizations such as AARP must advocate for increases for HCBS on an annual basis. Some years there are increases for HCBS, and some years not. And Michigan's long term care system continues to direct more people into nursing homes than necessary for other reasons, too, because the system continues to be structured in a way that favors that outcome.

WHAT ARE HOME AND COMMUNITY BASED SERVICES?

The terms "long term care" and "long term services and supports" (LTSS) refer to the broad range of paid and unpaid medical and personal care assistance that people may need – for several weeks, months, or years – when they experience difficulty with self-care tasks as a result of aging, chronic illness, or disability. These self-care tasks are referred to as *activities of daily living*, such as eating, bathing, and dressing, and instrumental *activities of daily living*, which are slightly more complex skills, such as preparing meals, managing medication, and housekeeping.

The majority of long term care in the U.S. is provided by unpaid family caregivers, and there are nearly 1.3 million family caregivers in Michigan. However, as a person's care needs become more extensive, paid LTSS delivered by direct care workers may be required.

Direct care may be provided by medical professionals such as nurses, or paraprofessionals such as nurse aides or personal attendants. Of particular note for this paper, LTSS includes both institutional care and home and community-based services (HCBS). HCBS includes home health aide services, personal care services, adult day programs, transportation, respite, caregiver training, care coordination services and more. They may be services that are provided in the individual's home, or in another home-like setting, or services may be delivered outside of the home but in the person's community, such as at an adult day program.

Access to these services can be life-changing for older adults and their families. Often, simply providing assistance with self-care tasks can be the difference that allows someone to remain in their own home, rather than go to a nursing home. These services can also be the difference that allows an individual's family caregiver to remain in the workforce, earning income and avoiding lost productivity for Michigan businesses.

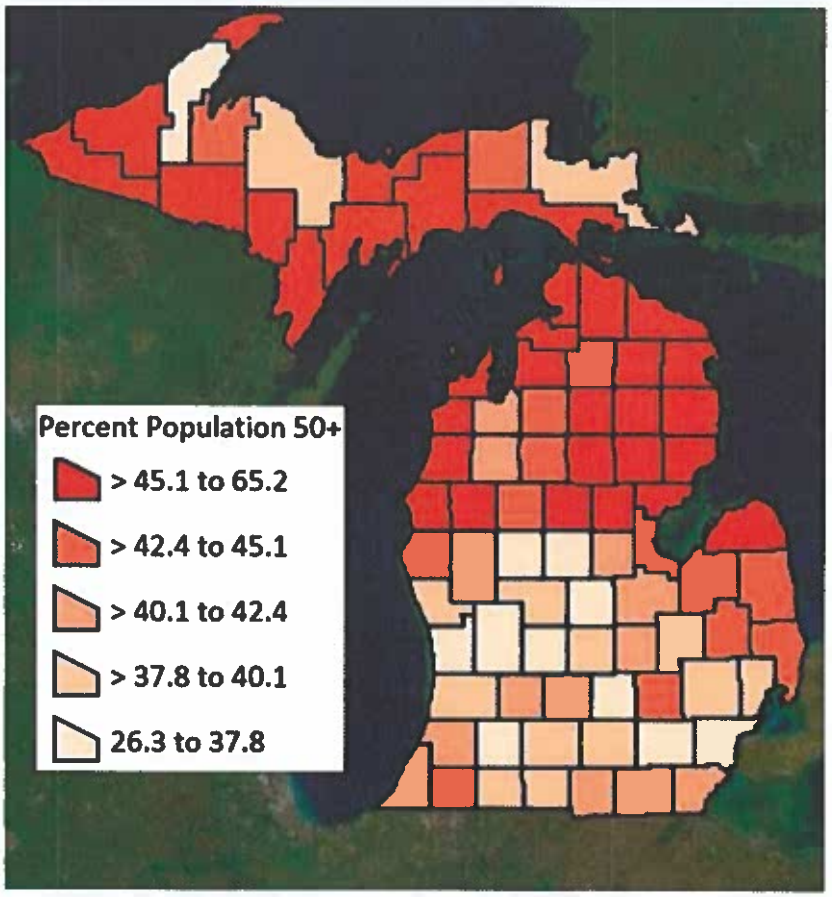
BECOMING A MORE AGE FRIENDLY STATE

Michigan is one of the most rapidly aging states in the nation. By 2024, Michigan will become the first state where residents age 65 and over will outnumber those under the age of 18.[7]

The percentage of residents age 65 and over – now at approximately 15% – is expected to increase to nearly 22% by 2050. The percentage of residents age 85 and up is expected to more than double, from 2.2% in 2015 to 4.8% in 2050. Already in 2021, 38.5% of Michigan's population is age 50 and over, and in 23 of Michigan's 83 counties, the majority of the total population is already age 50 or over.

In October 2019 the State of Michigan took the forward-looking step of joining the AARP Network of Age Friendly States and the World Health Organization Global Network of Age Friendly Cities and Communities, becoming only the fifth state in the nation to do so.

Improving Michigan's long term care system is a crucial component of being an Age Friendly State is to ensure that people can age in place in their homes and communities, living there comfortably throughout their lifetimes.



Source: Claritas, Inc. and AARP MUL 2021. Prepared by AARP Research.

CURRENT OPPORTUNITIES FOR ONE-TIME FUNDING

The State of Michigan will receive an influx of one-time federal funds under the American Rescue Plan Act (ARPA) of 2021. Some of these funds are specifically designated for enhancing, expanding, or strengthening home and community-based services. Others are not specifically designated for long term care, but it is permissible to use them for these purposes. In both cases, AARP believes using one-time funds to transform Michigan's long term care system makes sense, especially in light of the vulnerabilities the coronavirus pandemic exposed in the current system.

Of particular note, Section 9817 of the American Rescue Plan Act provides states with a temporary 10-percentage point increase in the federal medical assistance percentage (FMAP) to "enhance, expand, or strengthen HCBS under the Medicaid program."[9] Michigan is expected to receive **$139 million** in new one-time federal funding under Section 9817, and the state will have until March 31, 2024 to spend those funds.[10]

Guidance from the Centers for Medicare and Medicaid Services (CMS) provides that these funds can be used to increase access to HCBS for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long term services and supports (LTSS) reform. According to CMS, states will be allowed wide latitude to use the funds for a variety of services development, HCBS infrastructure, and state risk mitigation functions that have been serious obstacles to rebalancing, but that have lacked a substantial federal funding source until now.

In addition to the funding specifically earmarked for HCBS under Section 9817, ARPA allocated $350 billion in more flexible Coronavirus State and Local Fiscal Recovery Funds of which the State of Michigan is slated to receive approximately **$6.5 billion**.

As described in guidance from the U.S. Department of Treasury, these funds are available for the State of Michigan to use for eligible purposes including supporting public health and addressing negative impacts caused by the coronavirus pandemic.[11] States have broad flexibility to decide how best to use this funding. Given the devastating impact of the coronavirus on residents of nursing homes and the vulnerabilities in the current nursing home industry that were exposed during the current pandemic, rebuilding Michigan's nursing homes in new ways to withstand the next pandemic needs to be a priority for this spending. Better options can help ensure that the tragedy currently unfolding in nursing homes never happens again.[12]

There are many potential proposals that AARP Michigan could support for the use of these funds that would increase access to HCBS and address needs in the system for the *short-term*. Different approaches are also possible to help advance the *long-term*

goal of rebalancing Michigan's long term care system to allow a greater number of older adults to age in place safely, independently and in good health.

The specific recommendations we present here are the ones that we believe have the most transformational potential for our state: ***specifically,* the potential to greatly improve the system in Michigan for the long run without requiring increased state spending after these new time-limited funds are exhausted.**

FIVE PROPOSALS

The investment of one-time funding could create a lasting impact and benefit older adults both in the short- and long-term by incentivizing a transformation of the long term care system in Michigan to encourage more capital investments in alternative long term care delivery models.

There are tried-and-true models such as Green House homes and PACE, as well as newer models such as Support and Services at Home (SASH), to provide independent senior housing with coordinated supportive services. These funds also provide an opportunity to shift the norm in Michigan away from favoring institutional settings.

This section describes 5 specific proposals that AARP believes are ripe for adoption in Michigan:

1) **Creating statewide HCBS presumptive eligibility**
2) **Expanding assisted/independent senior housing with coordinated supportive services**
3) **Providing HCBS start-up, expansion and innovation funding**
4) **Incentivizing small-house nursing homes (the Green House model)**
5) **Converting traditional nursing homes to 100% single occupancy rooms**

CREATING STATEWIDE HCBS PRESUMPTIVE ELIGIBILITY

Medicaid eligible individuals who experience a health crisis and require LTSS often end up in a nursing home because nursing homes are the only available LTSS providers that can be paid for their services while Medicaid eligibility is being determined by the state. Nursing homes operate under retroactive eligibility, which pays nursing homes back for services provided during the eligibility determination period.

This leads to individuals being institutionalized unnecessarily, and unfortunately, once someone requiring LTSS is settled in a nursing home, it is unusual for that person to ever return back home.

Providing *presumptive eligibility* for Medicaid-funded HCBS allows individuals to begin receiving HCBS immediately if a Medicaid applicant appears (is "presumed") likely to be both need- and income-qualified for a Medicaid-funded HCBS program. Michigan currently allows for "partial" presumptive Medicaid eligibility for HCBS. Currently, Michigan's presumptive eligibility program is only available for MI Choice Waiver program participants, rather than for all Medicaid HCBS programs, and it is only available in areas of the state where the local MI Choice Waiver Agency (typically the local Area Agency on Aging) has opted in to participate in presumptive eligibility. Under the current system a MI Choice Waiver Agency that opts in to provide presumptive eligibility is financially responsible for any services delivered during the presumptive period (often 45-180 days) if the state does not confirm their presumption after a full eligibility determination is completed. These factors combine to limit the benefits the state could otherwise realize if HCBS presumptive eligibility was more broadly available.

AARP recommends that Michigan broaden presumptive eligibility to include all its Medicaid HCBS programs, and that one-time funds currently available for enhancing HCBS under ARPA be used to create a statewide HCBS presumptive eligibility loss pool to cover the startup costs of doing so.

During the start-up of presumptive eligibility programs, there are launch costs and potential short-term financial risks for states, the most significant being that the full costs of HCBS delivered during the determination period would need to be paid by the state if inexperienced staff make the wrong presumption and eligibility is not approved. (In mature programs, presumptive eligibility error rates have been found to be between 1% and 2%). To cover start-up costs and the risk associated with such a program, the state could use one-time funding to implement a statewide presumptive eligibility program, including a loss reserve to cover any mistakes the state makes in eligibility determinations during the first year of the program. Any remaining funds after the first year could be reassigned to another initiative.

It is an outdated element of Michigan's current long term care system that our Medicaid eligibility process still mostly presumes that the "normal" place for people to receive assistance with self-care tasks as they age should be in an institutional setting. This presumption runs contrary to both public preference and the core legal principle that individuals should be able to receive services in the least restrictive setting appropriate to the individual's needs.[13]

Using one-time funds under Section 9817 of ARPA to establish statewide presumptive Medicaid eligibility for HCBS programs would be a concrete step the State of Michigan could take to decrease the negative vestigial bias in our system toward institutional settings.

EXPANDING ASSISTED OR INDEPENDENT SENIOR HOUSING WITH COORDINATED SUPPORTIVE SERVICES

Programs of All-Inclusive Care for the Elderly (PACE) provide a comprehensive service delivery system and integrated Medicare and Medicaid financing for individuals age 55 and older who meet Medicaid's long term care eligibility criteria. Michigan currently has 22 PACE centers that cover only certain parts of the state, which means that PACE is currently unavailable to many Michigan residents who might otherwise qualify and who would benefit from receiving PACE services.[14] High PACE program start-up costs related to federal requirements hamper new PACE program development, particularly in areas without an established and well-funded organization interested in launching a program. While there has been increased interest recently from entities that want to establish new PACE centers in geographic areas that already offer PACE services, the need that exists is in those large swaths of the state where PACE is simply not available.

One-time funds could be used to provide financial incentives for qualified non-profit entities to establish PACE centers in areas that are currently unserved. The role of such funding would be to cover the high but non-recurring start-up costs that abate after the first year of operations, but that otherwise serve as a practical barrier to committed nonprofits without the capital or debt capacity to front those costs.

As is already required in Michigan, prospective PACE organizations would need to complete a feasibility study that includes evidence that the PACE organization "will either be cost neutral or save money for long term care services provided by the State in the service area."[15] Similarly, financial incentives could be offered to incentivize the development of other types of home and community-based services such as new independent senior housing options that provide coordinated supportive services, particularly in communities where HCBS options are currently limited.

On a national level, the National Well Home Network[16] is a source for potential innovative models, including the Support and Services at Home (SASH) program.[17] The SASH model provides population health services (wellness, prevention, and care management) to low-income older adults. Research shows that SASH helps older people live longer and more successfully in independent housing, with demonstrated savings to Medicare and Medicaid.[18] One or more SASH programs could be established regionally, serving a series of affordable or public housing organizations and their surrounding communities by making use of one-time funds, perhaps configured as a three-year demonstration project.[19]

PROVIDING HCBS START-UP, EXPANSION AND INNOVATION FUNDING

As described further in the **FINANCING MECHANISMS** section below, one-time funding could be used to allow a first-loss reserve and interest rate write down to create a low-cost revolving loan program to fund pre-development, start-up, and business expansion costs for viable HCBS and affordable housing projects not qualified for standard bank loans. This recommendation would help address the lack of HCBS provider capacity in low-income and rural areas in particular.

Increasing access to HCBS for low-income populations eligible for Medicaid is the particular focus of Section 9817 of ARPA, which provides that the one-time funds attributable to Section 9817's increased FMAP rate must be used to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. However, these programs would also lead to benefits for "middle-income" families who quite often become "low-income" families after they spend down their live-savings to pay for long term care for an elderly family member.

Stakeholder involvement will of course be critical to the effective design of such a program, but the funds could be administered by the state Treasurer or a third-party such as a well-regarded community development financial institution (CDFI) with a track record in non-traditional health care lending.

One-time funding under ARPA could also be used to address other persistent public policy challenges facing Michigan's long term care system that the Michigan Department of Health & Human Services and stakeholders have as yet been unable to overcome, even though experts in the field are all aware that they loom over us. One looming problem is the direct care worker shortage. Another problem is the high cost of home and community-based services, which – even though typically much less than the

cost of nursing home care – puts these services out of reach for many middle class families, or sends families into financial distress.

AARP Michigan proposes using one-time funding to create grants to pilot innovative efforts to solve looming problems that have historically been unsolvable. Such an innovation fund would ideally feature an advisory panel to review proposals, and would provide funding for short-term or pilot efforts. An example of an innovative proposal could be to pilot a particular technological improvement or service model that helps family caregivers provide care for loved ones in their homes. Another example could be the creation of a model to address the issue of individuals who do not need in-home care 24/7 but who require assistance with activities of daily living (ADLs) that are *unscheduled but predictable*, such as assistance with brief changes for individuals who are incontinent (a/k/a fractional care for sporadic ADLs). The possibilities are wide, and exciting.

SMALL-HOUSE NURSING HOMES (THE "GREEN HOUSE" MODEL)

AARP proposes that one-time funding be invested to incentivize capital investment in Green Houses® or small-house nursing homes.[20]

The Green House model, first developed in the early 2000s, is the most widely researched small-house nursing home today. Green Houses or small-house nursing homes offer much higher quality of life for residents and higher family satisfaction,[21] but the availability of this opportunity for Michigan residents to age with dignity in a home-like setting with coordinated supportive services remains extremely limited.

Even before the coronavirus pandemic, longstanding problems in traditional nursing homes such as infection control violations, low staffing ratios, and safety concerns led some individuals and their families to seek alternative options, including small-house nursing homes. Research now also shows that residents of Green Houses or small-house nursing homes across the country fared significantly better than residents of traditional homes during the coronavirus pandemic, with residents of Green Houses facing significantly fewer cases of COVID-19 and fewer deaths from COVID-19.[22]

Green House and other small nursing home models are considered "nontraditional" due to their size (10-12 beds), home-like features, and the use of "universal caregivers" – a consistent, empowered work team of caregivers who are responsible for the range of personal, clinical, and home care activities. Small-house nursing homes also incorporate design elements that enable a safer living environment for people in need of nursing-home levels of care.

Currently, approximately 3,200 people nationwide live in Green House homes, including 6 Green House projects in Michigan.[23] The majority of residents receive nursing care and other services and supports such as personal care, hospice care and dementia care. Almost 9 in 10 Green House homes (87%) are licensed as skilled nursing facilities, and most of them are dually Medicare and Medicaid certified, allowing them to offer Medicare-covered short-term rehabilitation services as well as long term nursing home care.

Studies have found that, once they are up and running, the operational costs of small-house nursing homes are comparable to the operational costs of traditional nursing homes[24] even though small-house nursing homes offer better safety and resident satisfaction. However, start-up costs have been a barrier.

We urge the State of Michigan to explore the use of Coronavirus State and Local Fiscal Recovery Funds under ARPA as a source of one-time funding to incentivize Green House small-home nursing homes as an alternative to traditional nursing homes, recognizing the system-wide public health weaknesses that the pandemic exposed in institutional nursing home settings. Incentivizing capital investment in small-house nursing homes would help spur transformational change and have lasting benefits to improve the experience of aging in Michigan.

CONVERTING TRADITIONAL NURSING HOMES TO 100% SINGLE OCCUPANCY ROOMS

Finally, AARP urges the Michigan Legislature and Governor to find common ground to improve quality of life for nursing home residents, not only in response to COVID-19 but also to address longstanding concerns that have been around since before the pandemic.

As this paper has demonstrated, the focus in Michigan needs to be on *rebalancing* our current long term care system to increase access to services in home and community-based settings. That's where most people prefer to be, and it costs taxpayers less. Moving forward, nursing homes should no longer be considered the first or only setting available for the delivery of long term services and supports for older adults and people with disabilities in our state. However, for the minority of individuals who choose or otherwise end up in nursing homes, our state must do better. Safety demands it.

For this reason, AARP Michigan recommends using one-time Coronavirus State and Local Fiscal Recovery Funds available under ARPA to improve nursing home care by incentivizing the conversion of existing, traditional nursing homes to facilities consisting of 100% single occupancy rooms.

The conversion to single-occupancy should include design elements to ensure that residents have opportunities for healthy social engagement to avoid the negative effects of isolation. Additionally, any such incentives should require that the conversion to single occupancy be permanent, with claw-back requirements if a facility subsequently increases room occupancy levels.

Even before the coronavirus pandemic, the dense, dormitory-style of housing for residents in traditional institutional nursing homes made isolation and infection control difficult for a variety of reasons.[25] Hospital studies have long shown that single-occupancy rooms offer improved patient care and a reduction in the risk of cross infection.[26] Research now shows a higher incidence of COVID-19 associated with multi-resident rooms, showing that the more crowded nursing home rooms were, the higher the rate of COVID-19 infection and mortality.[27] A March 2021 report published by Health Management Associates entitled *Fundamental Nursing Home Reform: Evidence on Single-Resident Rooms to Improve Personal Experience and Public Health* found that, compared to multi-resident rooms, "Single-resident rooms are associated with decreased risk of facility-acquired infections, medication errors, resident anxiety, and incidence of aggressive behavior, while improving sleep patterns, sense of privacy, and satisfaction."[28]

Other states have recently announced the use of coronavirus relief funds to eliminate rooms with three or four beds in nursing homes.[29] Connecticut and Minnesota in particular have been leaders in repurposing and reimagining nursing homes and could offer models for efforts in Michigan to improve quality of care and resident safety.

PROTECTING NURSING HOME RESIDENTS AND STAFF

During the pandemic, AARP urged the Legislature to prioritize the following with regard to Michigan's long term care facilities:

- Ensuring that infection control measures are in place and that personal protective equipment is available and properly used.
- Ensuring that facilities carry out comprehensive testing for staff and residents.
- Facilitating virtual and when possible in-person visitation for residents with family and friends.
- Facilitating access for residents and family members to advocates from the Michigan Long Term Care Ombudsman program.
- Ensuring that nursing homes continue to be held accountable for providing the level of quality care required of them.

Nursing home residents have rights that are guaranteed under the federal Nursing Home Reform Act (42 CFR §483), which ensure individual dignity as well as safety.

FINANCING MECHANISMS

AARP welcomes the opportunity to work with policymakers to assist in developing specific plans for how the State might establish effective programs that use one-time funds to create the types of financial incentives we are proposing in this paper. Examples for making use of one-time funds in this way include:

- ***Creation of an LTSS Pre-Development Loan Fund***
  Many smaller businesses and non-profits, especially in underserved areas, lack the funds or investors required to finance start-up costs. An LTSS pre-development loan fund could make use of one-time state funds to provide no-cost or low-cost loans for providers of the types of long term services and supports the state wants to incentivize. Then, as loans are paid back, the fund could continue as a revolving fund.

- ***Creation of an LTSS Subordinated Loan Fund for Owner-Equity and Working Capital***
  Conventional commercial lending structures generally require that 25-40% of a project's or business's financial needs be met through owner contributed risk capital (aka "equity") to insulate the remaining secured debt from potential losses. For many financially viable LTSS businesses, affordable senior housing projects, and long term care programs, the required equity is difficult or impossible to raise due to the lack of competitive investment returns for businesses serving majority Medicaid populations. A subordinated loan (i.e., a loan that is only paid after the primary loan payments are satisfied) can act as an equity stand-in. An LTSS subordinated loan fund focused on expanding access to HCBS, affordable senior housing and service models, and innovative models of licensed care settings would help new HCBS businesses develop, providing the capacity necessary to rebalance the delivery of LTSS in Michigan and create impactful, positive change for years to come.

A CALL TO ACTION

The State of Michigan currently faces the following challenges and opportunities:

- Eighty-nine percent (89%) of Michigan voters want to avoid ever living in a nursing home. If or when they need long term care services, they prefer to stay at home, or in a home-like, community setting. The tragic experiences of COVID-19 highlighted the deficiencies of Michigan's current long term care system and reinforced existing public negative opinions about traditional nursing homes.

- Alternatives to traditional institutional settings exist that allow people to age in place by receiving long terms supports and services in home and community-based settings. However, access to such services is currently limited in Michigan due to funding constraints and a lack of HCBS providers in underserved areas.

- Once in place, ongoing costs for HCBS are significantly lower than costs for care in residential settings, and the Green House innovations described in this paper have similar operating costs to traditional nursing homes. However, access to the affordable capital needed for start-up costs continues to be a significant barrier, especially for settings intended to serve low- or moderate-income persons.

- One-time federal funding is now available to the State of Michigan that could be used to fund the proposals described in this paper, including both billions of dollars in Coronavirus State and Local Fiscal Recovery Funds and $139 million in new one-time federal funding under Section 9817 of the American Rescue Plan Act (ARP) of 2021.

Michigan's long term care system is currently locked in a broken cycle in which we continue to spend too much taxpayer money for care in settings that are both *more expensive* than alternatives, and *not* what Michigan residents want for themselves and their families. There is a pressing need to transform Michigan's long term care system.

The recommendations set forth in this paper would jumpstart efforts to rebalance Michigan's long term care system and spur the sorely-needed development that will deliver that transformation. These proposals have the ability to improve quality of life for millions of Michiganders. Not only are they life changing and sustainable, they also represent the voices of the people we serve.

AARP appreciates the opportunity to engage with policymakers and stands ready to assist in any way we can to help ensure the successful implementation of these proposals. Thank you for the opportunity to be part of the process as we work together to achieve this great vision for our great state.

ENDNOTES

[1] Survey of Registered Voters in Michigan - Age 50 & Over. Conducted by EPIC/MRA for AARP Michigan (August 2020)

[2] *Long-Term Services & Supports State Scorecard: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, AARP, Commonwealth Fund, and SCAN Foundation (October 2020) http://longtermscorecard.org/2020-scorecard/preface

[3] *Stretching the Medicaid Dollar: Home and Community-Based Services Are a Cost-Effective Approach to Providing Long-Term Services and Supports*, AARP Public Policy Institute (February 2017) http://www.aarp.org/content/dam/aarp/ppi/2017-01/Stretching%20Medicaid.pdf

[4] *Gradual Rebalancing of Medicaid Long-Term Services and Supports Saves Money and Serves More People, Statistical Model Shows*, Health Affairs (June 2012) http://content.healthaffairs.org/content/31/6/1195

[5] *Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs*, Journal of Health and Social Policy (2006) https://www.semanticscholar.org/paper/Institutional-and-community-based-long-term-care%3A-a-Kitchener-Ng/cf751c6eae314164c18cdf9fee29d117bb959799

[6] *Michigan: 2020 Long-Term Services and Supports (LTSS) State Scorecard*, AARP, Commonwealth Fund, and SCAN Foundation (October 2020) http://longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/Michigan%20Fact%20Sheet.pdf

[7] The definition of "nursing home" in Michigan is set forth in Section 20109 of the Public Health Code, MCL 333.20109:

> (1) "Nursing home" means a nursing care facility, including a county medical care facility, that provides organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity. As used in this subsection, "medical treatment" includes treatment by an employee or independent contractor of the nursing home who is an individual licensed or otherwise authorized to engage in a health profession under part 170 or 175. Nursing home does not include any of the following:
>
> (a) A unit in a state correctional facility.
> (b) A hospital.
> (c) A veterans facility created under 1885 PA 152, MCL 36.1 to 36.12.
> (d) A hospice residence that is licensed under this article.
> (e) A hospice that is certified under 42 CFR 418.100.
>
> ...
>
> (4) "Skilled nursing facility" means a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or a distinct part thereof, certified by the department to provide skilled nursing care.

[8] U.S. Census Bureau data show the state's population of those 65 years old and older has risen nearly 30% since 2010 as baby boomers continue to age. Over the same time, the number of people younger than 20 years old has dropped 9% amid the state's lowest birth rates on record. Kurt Metzger, demographer and director emeritus of Data Driven Detroit, estimates that Michigan's 65 and older population will surpass those younger than 18 by 2024, a decade before such a "cross over" is predicted to happen in the United States. That mark is expected to be reached by 2026 in southeast Michigan, according to the Southeast Michigan Council of Governments. https://www.detroitnews.com/story/news/local/michigan/2020/08/12/michigan-aging-population-imperils-taxation-spending-priorities-covid-19-lowers-birth-rate/3249202001/

[9] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.

[10] Based on estimated Medicaid HCBS spending from the period from April 1, 2021 to March 31, 2022 https://www.kff.org/report-section/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities-table/

[11] https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments/state-and-local-fiscal-recovery-funds

[12] *Long-Term Care Policy after Covid-19 — Solving the Nursing Home Crisis,* Werner, Rachel et al, New England Journal of Medicine (September 3, 2020) https://www.nejm.org/doi/full/10.1056/NEJMp2014811

[13] The landmark ruling by the United States Supreme Court in *Olmstead v. L.C.,* 527 U.S. 581 (1999), held that state governments may not operate programs in a way that unnecessarily forces people with disabilities to live in nursing homes.

[14] Find the list of current PACE providers in Michigan here:
https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-87437--,00.html

[15] "Prospective PACE organizations must complete a feasibility study which includes providing evidence the PACE organization will either be cost neutral or save money for long term care services provided by the State in the service area."
https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-87437--,00.html

[16] https://www.wellhome.org/resources/

[17] https://sashvt.org/ and https://www.huduser.gov/portal/periodicals/cityscpe/vol20num2/ch1.pdf

[18] *Healthy Housing: An Evaluation of Self Help Active Services for Aging Model*
https://www.selfhelp.net/pdf/events/Selfhelp%27s%20Healthy%20Housing%20White%20Paper.pdf

[19] SASH relies on economies of scale with several panels of 100 participants, so this would best suit a region where several affordable senior housing organizations want to participate. Affordable or public housing settings make sense in particular because they likely already have residents living there who are on Medicaid.

[20] *Nontraditional nursing homes have almost no coronavirus cases. Why aren't they more widespread?*
https://www.washingtonpost.com/local/green-house-nursing-homes-covid/2020/11/02/4e723b82-d114-11ea-8c55-61e7fa5e82ab_story.html

[21] *Small-House Nursing Homes,* Reinhard, Susan and Hado, Edem. AARP Public Policy Institute (2021).
https://www.aarp.org/content/dam/aarp/ppi/2021/small-house-nursing-homes.pdf

[22] *Nontraditional Small House Nursing Homes Have Fewer COVID-19 Cases and Deaths,* The Journal of Post-Acute and Long-Term Care Medicine, Published: January 25, 2021
https://www.jamda.com/article/S1525-8610(21)00120-1/fulltext

[23] https://www.thegreenhouseproject.org/about/find-a-home

[24] *Financial Implications of THE GREEN HOUSE® Model,* Jenkens, Robert et al, Senior House & Care Journal (2011). http://www.chipartners.net/wp-content/uploads/2012/10/Green.House_.Article.pdf

[25] *Strengthening Nursing Home Policy for the Postpandemic World: How Can We Improve Residents' Health Outcomes and Experiences?* The Commonwealth Fund (2020).
https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/strengthening-nursing-home-policy-postpandemic-world

[26] *The Use of Single Patient Rooms versus Multiple Occupancy Rooms in Acute Care Environments*, Coalition for Health Environments Research (2004)
https://www.healthdesign.org/sites/default/files/use_of_single_patient_rooms_v_multiple_occ._rooms-acute_care.pdf

[27] *Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada* (2020)
https://www.medrxiv.org/content/10.1101/2020.06.23.20137729v1

[28]*Fundamental Nursing Home Reform: Evidence on Single-Resident Rooms*, page 5 (March 2021)
https://www.healthmanagement.com/wp-content/uploads/HMA.Single-Resident-Rooms-3.22.2021_final.pdf

[29] https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2020/12-2020/Governor-Lamont-Commits-an-Additional-31-Million-To-Support-Nursing-Homes

AARP PROPOSALS FOR USING ONE-TIME FUNDS TO TRANSFORM MICHIGAN'S LONG TERM CARE SYSTEM

AARP Michigan

The heartbreaking loss of life in nursing homes due to COVID-19 and the isolation that left countless others disconnected from loved ones should be a wakeup call for Michigan. Our long term care system is in urgent need of reform. AARP's recent white paper, *Home at Last: The Historic Opportunity to Transform Michigan's Long Term Care System Using One-Time Funding in 2021,* lays out specific recommendations for how Michigan policymakers can use one-time funds available under the American Rescue Plan Act (ARPA) to transform the long term care system to improve safety and quality of life for older adults now and for the future. This fact sheet provides estimates of the cost to implement each of the recommendations from our white paper.

Proposal	ARPA Funding Source	Estimated Cost to Implement	Benefits
Expand Michigan's current partial presumptive eligibility for Medicaid HCBS programs (page 7)	ARPA Section 9817 (enhanced FMAP) HCBS funding	**STUDY** **$500K** to commission a 1-year study of Michigan's current partial presumptive eligibility program regarding MI Choice and make recommendations for improvements, statewide MI Choice adoption, and other Medicaid HCBS programs.	Expanding presumptive eligibility would help prevent individuals who are presumed to be Medicaid eligible from being institutionalized unnecessarily, by ensuring nursing homes aren't their only option for long term supports and services while they await Medicaid determination.
		RISK POOL **$5 million** to develop a statewide risk pool to cover 90% of MI Choice waiver agents' exposure to losses associated with incorrect presumptive eligibility determinations for Medicaid HCBS and limit that exposure to 6 weeks. • Expands MI Choice waiver agents' use of presumptive eligibility by limiting their total financial exposure to a manageable level • Maintains waiver agents' incentive for careful presumptive eligibility assessments through a 10% share of the liability • Limits waiver agents' shared liability to 6 weeks of services costs, placing the financial onus of delayed determinations on the state • Presumptive eligibility error rates have been found to be between 1% and 2% • For cost comparisons in other states see OH, RI, VT, & WA.	
Expand assisted or independent senior housing with coordinated supportive services (page 8)	ARPA Section 9817 (enhanced FMAP) HCBS funding	**PACE** New PACE programs could be established in Alpena, Marquette and Sault St Marie, and/or other areas that do not currently have PACE. See PACEMichigan.com for current sites. Startup costs for an average size PACE typically run from $3 million to $5 million. (*Note:* We also support increased funding for current PACE programs to offset losses due to COVID.) • If our proposed LTSS Loan Funds were used, **$15 million** could help 5 new sites get established, providing low-interest *first position debt* for the programs at $3 million per site, OR **$3.75 million to $6.25 million** could help 5 new sites get established if the state prefers to leverage conventional debt by providing *subordinated debt*, with each project benefitting from $750K to $1.2 million in subordinated debt each.	As is already required in Michigan, prospective PACE organizations would need to complete a feasibility study that includes evidence that the PACE organization "will either be cost neutral or save money for long term care services provided by the State in the service area."
		SASH **$5.6 million** to establish a 2-year SASH demonstration for 15 panels of 100 Medicaid-eligible people at various locations in the state (1,500 total participants). Represents $4.85 million for program costs plus $750K to evaluate the demonstration. • National Well Home Network (wellhome.org) can provide technical assistance. • Vermont offers a statewide model.	Research shows that SASH helps older people live longer and more successfully in independent housing, with demonstrated savings to Medicare and Medicaid.

Proposal	ARPA Funding Source	Estimated Cost to Implement	Benefits
Provide HCBS start-up, expansion and innovation funding (page 9)	ARPA Section 9817 (enhanced FMAP) HCBS funding	**PRE-DEVELOPMENT LOAN FUND** **$20 million** in forgivable lending capital would provide pre-development loans averaging $100K to 200 Michigan businesses focused on serving Medicaid eligible HCBS consumers, funding the exploration of about 2.5 new or expanded HCBS business per MI county in the first round of loans (e.g., before the fund begins to revolve after 12 - 24 months). • Individual loans would be expected to range from a low of $25K for a small local business to a high of $500K for a PACE program, with most in the $50 - $250K range, for an average of $100K per loan. • If 85% of the loans (170 of them) result in a new or expanded HCBS business serving, on average, 50 consumers, the program could provide an additional 8,500 Michiganders with HCBS services. • Alternatively, the Pre-Development Loan Fund could be scaled larger or smaller. **SUBORDINATED LOAN FUND** **$42.5 million** in lending capital would fund the 170 projects found viable under the Pre-Development Loan Program (above) at an average of $250K each. • Individual project costs would be expected to range from a low of $250K for a small local business to a high of $5 million for a PACE program, averaging $1 million per project. • The Subordinated Loan Fund would typically provide 25% of project costs, with 60% coming from a conventional lender and 15% being provided by the owner. However, in the case that a project is viable but no conventional lender is available, the Loan Fund could provide more than 25%, in some cases providing up to 85% of the project costs. • The Subordinated Loan Fund could be scaled larger or smaller. **INNOVATION GRANTS** **$12.5 million** could provide 50 grants averaging $250K/each to help non-profits or small businesses pilot innovative HCBS programs by offsetting their predevelopment and/or start-up costs.	Studies show that states that provide a higher proportion of the long term care their residents need through home and community services save money.[ii] Medicaid dollars can support nearly three older adults or people with disabilities in home and community-based services for every one person in a nursing home.[iii] Statistical modeling found that increasing the portion of Medicaid LTSS dollars toward HCBS by 2 percentage points annually can reduce overall Medicaid LTSS spending by 15 percent over 10 years.[iv] *Please see AARP's accompanying fact sheet entitled "Establishing LTSS Loan Funds to Incentivize Long Term Care Options In Michigan" for more about these financing mechanisms and options for scaling.*
Incentivize Green Houses, also known as the small house nursing home model (page 10)	ARPA Coronavirus State & Local Fiscal Recovery Fund *(assuming licensing as nursing homes)*	**GREEN HOUSES** Green Houses or small-house nursing homes offer a much higher quality of life for residents day-to-day and had a much lower incidence of infection and death from COVID-19 during the pandemic. However, their availability is currently extremely limited for Michigan residents: there are only 6 in the state. (See TheGreenHouseProject.org.) Construction and startup costs are estimated at from $1.75 million to $2.5 million for a single Green House home, with on average 10-12 beds. **$15.0 million** could help 5 new Green House campuses of 5 homes each get established (25 homes total), assuming an estimated $500K in predevelopment loan funding per campus and $500K in subordinated debt per Green House home.	Once they are up and running, the operational costs of small-house nursing homes are comparable to the operational costs of traditional nursing homes[v] while also providing documented resistance to infectious disease,[vi] better safety and higher resident and family satisfaction.

Proposal	ARPA Funding Source	Estimated Cost to Implement	Benefits
Convert traditional nursing homes to 100% single occupancy rooms (page 11)	ARPA Coronavirus State & Local Fiscal Recovery Funds	**SINGLE OCCUPANCY ROOMS** A recent report by Health Management Associates[vii] provides an initial estimate of an increase in operating cost of $16-25 per resident per day and capital costs of $20-40 per resident day for converting to single occupancy. **$126.5 million** would pay for the median additional provider operating and capital costs associated with converting about 24,000 Medicaid funded nursing home resident rooms to private rooms for one year. ($51/day*365 days*24K = $447MM, less 71.68% FMAP = $126.5MM) ***Rather than*** face a higher ongoing state obligation per patient day to cover these capital costs, AARP proposes that the state use ARPA funding to offset some of these capital costs up front. An **independent study and/or pilot** could be developed to determine the most cost-effective way to fund this conversion.	Research shows a higher incidence of COVID-19 associated with multi-resident rooms, showing that the more crowded nursing home rooms were, the higher the rate of COVID-19 infection and mortality.[viii] Single-resident rooms are associated with decreased risk of facility-acquired infections, medication errors, resident anxiety, and incidence of aggressive behavior, while improving sleep patterns, sense of privacy, and satisfaction."[ix]

For more information, please contact AARP Michigan's Associate State Director for Government Affairs, Melissa Seifert, at 517-316-6393 or mseifert@aarp.org.

10.12.2021

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[i] *Healthy Housing: An Evaluation of Self Help Active Services for Aging Model* https://www.selfhelp.net/pdf/events/Selfhelp%27s%20Healthy%20Housing%20White%20Paper.pdf

[ii] *Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs*, Journal of Health and Social Policy (2006) https://www.semanticscholar.org/paper/Institutional-and-community-based-long-term-care%3A-a-Kitchener-Ng/cf751c6eae314164c18cdf9fee29d117bb959799

[iii] *Stretching the Medicaid Dollar: Home and Community-Based Services Are a Cost-Effective Approach to Providing Long-Term Services and Supports*, AARP Public Policy Institute (February 2017) http://www.aarp.org/content/dam/aarp/ppi/2017-01/Stretching%20Medicaid.pdf

[iv] *Gradual Rebalancing of Medicaid Long-Term Services and Supports Saves Money and Serves More People, Statistical Model Shows*, Health Affairs (June 2012) http://content.healthaffairs.org/content/31/6/1195

[v] *Financial Implications of THE GREEN HOUSE® Model,* Jenkens, Robert et al, Senior House & Care Journal (2011). http://www.chipartners.net/wp-content/uploads/2012/10/Green House_.Article.pdf

[vi] *Nontraditional Small House Nursing Homes Have Fewer COVID-19 Cases and Deaths,* The Journal of Post-Acute and Long-Term Care Medicine, Published: January 25, 2021 https://www.jamda.com/article/S1525-8610(21)00120-1/fulltext

[vii,ix] *Fundamental Nursing Home Reform: Evidence on Single-Resident Rooms*, page 5 (March 2021) https://www.healthmanagement.com/wp-content/uploads/HMA.Single-Resident-Rooms-3.22.2021_final.pdf

[viii] *Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada* (2020) https://www.medrxiv.org/content/10.1101/2020.06.23.20137729v1