Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

THE EXTENT AND IMPACT OF UNMET IN-HOME SERVICE NEED ON MICHIGAN'S NON MEDICAID ELIGIBLE SENIORS, ADULTS WITH DISABILITIES AND THEIR CAREGIVERS

February, 2014

The Silver Key Coalition is a group of individuals and organizations committed to supporting the desire of older adults and adults with a disability to remain living independently in their own home for as long as possible. The Coalition recognizes that having a key to one's own home is one of the most important quality of life elements, and advocates for a $10 million multi-year increase in state supported in-home services through the Michigan Office of Services to the Aging. The Coalition goal is to make Michigan a "no wait state" for in-home services, beginning with a $5 million increase in state funding for FY 2015.

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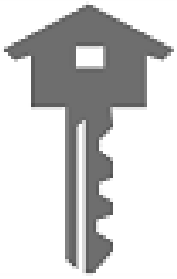

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EXECUTIVE SUMMARY

State supported home and community based services provide the basic necessities that help enable seniors to stay safely in their housing of choice. The need for these services exceeds availability, forcing seniors to wait for help and bear the negative consequences of going without. As a result, thousands of Michigan seniors languish on wait lists for key in-home services made available through the Michigan Office of Services to the Aging (OSA) like personal care, homemaking and home delivered meals, with little hope for assistance. This White Paper was developed by the Silver Key Coalition to document the impact of in-home service wait lists, underserving and unmet needs, and support its goal of making Michigan a no wait state for in-home services.

Key Findings:

- In 2014 there are nearly 4,500 seniors languishing on wait lists for basic services such as home-delivered meals and help with bathing, dressing, medication, shopping and household chores. About half of the individuals on the wait lists have been waiting for more than 180 days.
- Individuals on wait lists for extended periods of time are:
    - More likely to end up living in a nursing home
    - Less likely to remain living in their own home
    - More likely to seek health care from a hospital emergency room
    - More likely to die waiting for assistance.
- An increase of $5 million for the fiscal year 2015 will be needed to allow the Michigan Office of Services to the Aging in-home services programs to begin addressing the service needs of those on wait lists, accommodate anticipated new requests for assistance, and begin addressing the needs of the underserved population of individuals who are receiving assistance, but not in the amount that they need due to service rationing.
- The effort to make Michigan a “No Wait State” for in-home services will be a key component of a larger strategy to make Michigan a retirement destination of choice that attracts and retains retirees, and captures the significant social and economic benefits of an aging population.
- A $5 million investment will yield many collateral benefits to taxpayers, businesses and the state, including:
    - Creating approximately 200 new jobs
    - Return approximately $350,000 in state tax revenue
    - 75% of food purchased from Michigan based sources

A FY 2015 allocation increase of $5 million in state general revenue funding for in-home services provided through the Michigan Office of Services to the Aging, coupled with the leveraging of participant donations and other funding sources, will represent an important step in eliminating the state’s chronic in-home service wait lists of older Michiganians.

PURPOSE STATEMENT/INTRODUCTION

Research consistently shows that the vast majority of older adults wish to remain in their homes as they age as opposed to more institutional settings. A 2011 AARP survey found, "nearly 90 percent of people over age 65 want to stay in their home for as long as possible, and 80 percent believe their current residence is where they will always live. However, for older adults to age in place, their physical and service environment must be accommodating[1]." State supported home and community based services provide the basic necessities that help enable seniors to stay safely in their housing of choice. The need for these services exceeds availability, forcing seniors to wait for help and bear the negative consequences of going without.

As a result, thousands of Michigan seniors languish on wait lists for key in-home services made available through the Michigan Office of Services to the Aging (OSA) like personal care, homemaking and home delivered meals, with little hope for assistance. At the beginning of FY 2014 there were 3,568 seeking help with in-home services and over 952 requesting home delivered meals due to their difficulty being able to perform necessary activities of daily living such as meal preparation, grooming, bathing, etc. A recent survey of those on in-home service wait lists found dire consequences for individuals, family caregivers, and taxpayer-supported state services when they are denied the help needed to remain living independently in a safe and supported environment. Within two years after being placed on a wait list those who received no help were:

- Five times more likely to be living in a nursing home
- 20% less likely to be still living in their own home
- Twice as likely to have received treatment from a hospital emergency room in the past 90 days
- 25% more likely to have died

The increased burden on disabled seniors' family caregivers was also significant:

- Caregiving was three times more likely to interfere with their work
- Caregivers were five times more likely to have suffered a financial loss due to their caregiving responsibilities[2]

The wait list problem has been compounded by an annual 2% increase of about 50,000 Michigan seniors and the loss of $8.1 million in state support for OSA programs since 2009.

The purpose of this white paper is to document the extent and impact of unmet in-home service needs among older Michiganians and adults with a disability, as well as the impact on family caregivers. The paper provides data that justifies an increase in state support for in-home services targeted to near-poor individuals who do not qualify for welfare or other Medicaid long term care programs.

The paper has been prepared by the Silver Key Coalition, a group of individuals and organizations committed to supporting the desire of older adults and adults with a disability to remain living independently in their own home for as long as possible. The Coalition recognizes that having a key to one's own home is one of the most important quality of life elements, and advocates for a $10 million multi-year increase in state supported in-home services through the Michigan Office of Services to the Aging. The Coalition goal is to make Michigan a "no wait state" for in-home services, beginning with a $5 million increase in state funding for FY 2015.

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[1] (2011). Aging in place: A state survey of livability policies and practices. *In Brief*, *190*, Retrieved from http://www.aarp.org/home-garden/livable-communities/info-11-2011/Aging-In-Place.html

[2] Based on a study of two-year outcomes for 1,471 individuals placed on in-home service wait lists in Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw counties in 2008, conducted by Area Agency on Aging 1-B.

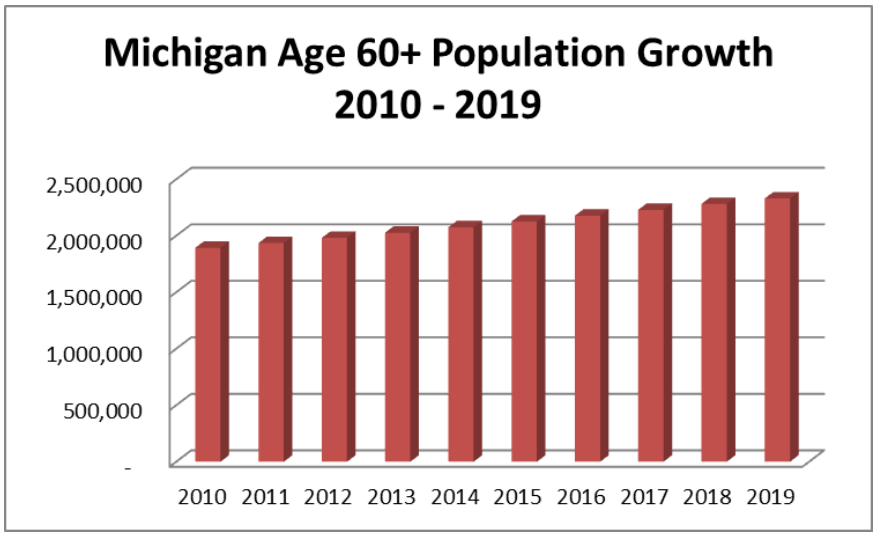
DEMOGRAPHICS

MICHIGAN'S OLDER ADULT POPULATION GROWTH

Michigan's age 60 and older population exceeds 2 million, will increase by over 50,000 in 2014, and will continue at that level of annual increases throughout the rest of the decade according to the US Census Bureau population projections.[3] This represents a growth rate of 141 more seniors each day. In contrast, every other age group is expected to decline.

Michigan has more seniors age 60 and older than school age children (ages 5 – 19).

6% of the 2014 senior population increase is for the age 85 and older population (3,147), which is increasing at a rate of 60 more seniors each week, and which represents the population that is the highest users of home and community-based services. The growth figures suggest a potential annual growth in home and community-based service demand of approximately two percent for the remainder of the decade based on population alone.



Annual Growth of Michigan 60 and Older Population

Year	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***	***2016***	***2017***	***2018***
60+	1,892,731	1,935,541	1,981,026	2,027,038	2,074,944	2,126,668	2,177,017	2,229,323	2,281,412
Increase	42,810	45,485	46,012	47,906	51,724	50,349	52,306	52,089	48,301
Percent	2.26%	2.35%	2.32%	2.36%	2.49%	2.37%	2.40%	2.34%	2.12%

PREVALENCE OF DISABILITY IN MICHIGAN

Of the 4,092,847 adults in Michigan age 18-59, almost one in six of them are living with a disability. For adults over age 60 the prevalence of disability increases to almost one in three.[4]

	Total Population	**Population with a Disability**
Total Age 18+	6,104,749	1,240,906 (20%)
Age 18-59	4,092,847	603,133 (15%)
Age 60+	2,011,902	637,773 (32%)

[3] File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030. Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

[4] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates (Tables S1810 ,B18108, and S0102)

Not only are there almost 1.25 million adults in Michigan with a disability, but 10%, or 627,158 of those individuals suffer from multiple disabilities. Multiple disabilities are especially prevalent in the population over age 65, where nearly 20% have two or more disabilities.[5]

The table below details the estimated number of adults in Michigan living with each type of disability.[6]

	Total Population	Any Disability	Two or More Disabilities	Independent Living	Self-Care	Ambulatory	Hearing	Vision	Cognitive
Adults 18+	6,104,749	1,240,906	627,158	499,061	266,503	700,648	347,592	187,921	452,347
% of Adults 18+		20%	10%	8%	4%	11%	6%	3%	7%
Adults 65+	1,404,130	505,535	354,776	220,213	119,385	316,381	210,181	82,342	127,077
% of Adults 65+		36%	25%	16%	9%	23%	15%	6%	9%

The two disability categories that are relevant in this paper are self-care difficulty, defined as "difficulty dressing or bathing" and independent living difficulty, defined as "difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition." (2011 Disability Status Report Michigan) These definitions lead to the assumption that people with a self-care difficulty correspond with those who have difficulty performing at least one activity of daily living (ADL) and that people with an independent living difficulty can also be said to have difficulty with at least one instrumental activity of daily living (IADL).

Based on this assumption, it is estimated that 266,503 people in Michigan, 119,385 (45%) of whom are over the age of 65, have difficulty with an activity of daily living. Additionally, 499,061 people have difficulty with an instrumental activity of daily living, 220,213 (44%) of whom are over the age of 65. These figures are for the population living independently in the community, and exclude nursing home or assisted living facility residents.

IN-HOME SERVICE PARTICIPANT CHARACTERISTICS[7]

In-home services assist individuals with functional, physical, or mental characteristics that limit their ability to care for themselves and for whom informal supports (e.g., family or friends) are either unavailable or insufficient. Targeting for in-home services is based on social, functional, and economic characteristics. In 2013,

[5] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates (Tables S1810 ,B18108, and S0102)

[6] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates (Tables S1810 ,B18108, and S0102)

[7] All service, participant characteristic and expenditure contain in the report is preliminary data taken from the 2013 Michigan Aging Information System NAPIS Participant and draft Service Report prepared by the Michigan Office of Services to the Aging. This data is considered preliminary until such time that it has been submitted by the Michigan Office of Services to the Aging (OSA) as part of fiscal year 2013 State Program Report (SPR) and certified by the federal Administration on Aging.

19,585 older adults were supported by 748,087 hours/units of care management, case coordination and support, chore, homemaker, home health aide, and personal care provided through OSA. There were 51,187 home delivered meal participants who received 7,886,265 meals.

IN-HOME SERVICE PARTICIPANT PROFILE

In-home service participants are more likely to be female, live alone, have low income, be of advanced age, and report ambulatory, self-care, and independent living difficulties compared to Michigan's older adult population. A higher proportion of Michigan's older racial and ethnic minority populations and older rural population is served by OSA in-home services.

Participant Characteristics

In-Home Service Participant Characteristics	Home Delivered Meal Participant Characteristics
69% were 75 or older	67% were 75 or older
35% were 85 or older	35% were 85 or older
56% lived alone	49% lived alone
31% were low income	36% were low income
71% were female	65% were female

Participant Limitations in Ability to Perform Activities of Daily Living and Independent Activities of Daily Living

In-Home Service Participant ADL and IADL Limitations		Home Delivered Meal Participant ADL AND IADL Limitations	
Shopping	**66%**	Shopping	**76%**
Cleaning	**61%**	Cleaning	**54%**
Cooking meals	**62%**	Cooking Meals	**75%**
Using transportation	**55%**	Using Private transportation	**58%**
Stair climbing	**53%**	Stair climbing	**58%**
Doing laundry	**55%**	Doing laundry	**62%**
Walking	**50%**		

AT RISK PARTICIPANTS

Approximately 6.8% of in-home service participants (4,252) were classified as at-risk individuals who have specific activity of daily living limitations that are consistent with a nursing facility level of care[8]. This nursing home-eligible population was older, had lower incomes, and was at greater nutritional risk than the general in-home services population. Interestingly, they were less likely to live alone, presumably because they required such a high level of support that OSA in-home services were filling the gaps in care that family caregivers were unable to provide. These individuals at highest risk for institutionalization were disproportionately high users of case management and personal care.

[8] "At-Risk" includes in-home and home-delivered meals participants that require assistance with daily toileting, transferring, and mobility. These ADLs were selected based on Scoring Door 1 for the Michigan Medicaid Nursing Facility Level of Care Determination in MSA 04-15.

At-Risk Participant Service Utilization[9]

	Service Units	At-Risk Participants*	All Participants*	% At-Risk
Care Management	3,708	597	3,469	17.2%
Case Coordination & Support	2,647	308	8,632	3.6%
Chore	2,138	136	2,479	5.5%
Home-Delivered Meals	547,652	3,436	51,187	6.7%
Homemaker	28,650	409	7,541	5.4%
Personal Care	37,796	414	3,799	10.9%
Totals	**622,591**	**4,252**	**62,812**	**6.8%**
** Particpant totals are unduplicated*				

[9] At Risk Participant Data is for the combined in-home service and home delivered meal population.

IN-HOME SERVICE NEED

IN-HOME SERVICE WAIT LISTS[10]

Michigan Seniors on In-Home Services Waiting Lists as of October 1, 2013

Home Delivered Meals:

952

Other in-Home Services:

3,568

Total: 4,520

Michigan has a long history of chronic waiting lists for in-home programs supported through the Michigan Office of Services to the Aging (OSA). Wait lists exist when the demand for government subsidized services by individuals who cannot afford to purchase needed in-home assistance at private market rates, which in Michigan averages $19 an hour for homemaking workers and $20 an hour for home health aides[11], exceeds the supply of subsidized services in a given community, usually county-wide or region-wide. As a general rule, the federal funds provided through the Older Americans Act to states are insufficient to support the level of services needed by the state's older adult population to support independent living of disabled seniors. Adequately meeting needs requires contributions of state and/or local dollars that exceed minimum federal matching requirements. In Michigan, the largest portion of these additional dollars are provided locally through the 63 voter-approved county senior millages. The estimated $60 million in local senior millages raised annually is more than twice the amount of state funds allocated for senior services. Older adults living in communities with a senior millage are less likely to face a wait list when seeking services.

The OSA collects home delivered meal and other in-home service waiting list data from area agencies on aging on a quarterly basis. At the beginning of FY 2014, there were 952 individuals on waiting lists for home delivered meals and 3,568 on waiting lists for other in-home services in Michigan**.** 63% of Michigan's 16 area agency on aging regions have waiting lists for home delivered meals, and 88% have waiting lists for the other in-home services.

The absence of a wait list does not mean that there are no unmet service needs for a program or community. Many programs ration the amount of service to older adults, offering fewer hours or meals than are needed in order to extend at least some level of service to a higher number of individuals. There are also instances where some services have been completely eliminated. For example one out-of-home respite program was closed due to the FY 2013 sequestration cuts, despite having services reserved six months in advance. The wait list for this terminated service is no longer kept. Other examples of unmet needs in Michigan that are not documented by wait lists include home delivered meal recipients who need assistance with a second evening or weekend meal, offering chore services only to individuals with income below 150% of the federal poverty level, offering the choice of a chore service of lawn mowing or snow removal but not both, offering personal care clients one bath a week when two are requested, or offering time-limited subsidized services that require private pay for the full

[10] All service, participant characteristics and expenditures contained in the report are preliminary data taken from the 2013 Michigan Aging Information System NAPIS Participant and draft Service Report prepared by the Michigan Office of Services to the Aging. This data is considered preliminary until such time that it has been submitted by the Michigan Office of Services to the Aging (OSA) as part of fiscal year 2013 State Program Report (SPR) and certified by the federal Administration on Aging.

[11] Metlife, Metlife Mature Market Institute. (2012). *Market survey of long-term care costs*. Retrieved from website: https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf

cost of ongoing service. OSA receives information on underserving, but the information is difficult to accurately quantify, and no formal consolidated reports are available.

The study on the impact of long term presence on a wait list referenced elsewhere in this paper[12] found that going without services for one to two years significantly increases the possibility of negative consequences such as nursing home placement, forced move, lost work for family caregivers, and death. This is a troublesome issue for older Michiganians because approximately one in three seniors on a home delivered meals wait list have been waiting for meals longer than six months, and almost one half of individuals waiting for in-home services have been on a wait list longer than six months.

	Number on waiting list	Stay less than 30 days	30 to 60 days	61 to 179 days	Greater than 180 days	% Greater than 180 days
Home Delivered Meals	952	218	182	232	320	33.6%
Other In-Home Services	3,568	454	568	879	1,667	46.7%

OSA also collects data on the root causes of wait lists, and for those areas with wait lists, the limited availability of governmental or philanthropic funding to subsidize the cost of in-home services is the primary causal factor. Lack of funding is a cause for 69% of the areas with home delivered meals wait lists and it is the cause for 94% of areas with wait lists for other in-home services. Other causes relate to an inadequate infrastructure for service delivery, such as an inadequate volunteer or worker availability.

Demand Exceeds Service Availability due to:	HDM	In-Home
Limited funding for services	69%	94%
Limited service area/service delivery availability	19%	13%
Driver/worker shortage	19%	25%
Client choice	19%	38%

When individuals seeking in-home assistance are placed on a wait list, efforts are made to link them with other related community resources. The table below indicates the type of resources wait listed older adults are referred to, and the frequency at which they are referred.

AAA Assistance/Referrals are Provided to:	HDM	In-Home
Local non-AAA food assistance program (e.g., MiCAFE, Senior Project FRESH)	69%	75%
Local food bank/pantry shelf	56%	81%
Michigan Department of Human Services (DHS) office	50%	94%
HCBS/ED MI Choice Medicaid Waiver Program	50%	88%
ADRC/CLP options counseling for service options	25%	50%
Private pay program	38%	94%
Other assistance	32%	50%

[12] Based on a study of two-year outcomes for 1,471 individuals placed on in-home service wait lists in Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw counties in 2008, conducted by Area Agency on Aging 1-B

THE COST TO ELIMINATE IN-HOME SERVICE WAIT LISTS

The 2013 – 2014 Older Michiganians Day Platform calls for making Michigan a "No Wait List State" for in-home services. Based on inflation adjusted costs stated in the 2012 OSA NAPIS report, which is the most recent completed report available, it is a straightforward exercise to calculate the amount of dollars needed to provide a historically expected amount of in-home services to every individual on a wait list. The calculated cost to provide services for a year to all wait listed individuals carried into FY 2015 would be $3,325,823. This calculation assumes that the cost per unit of service would increase consistent with the projected rate of inflation[13] and that the distribution of service needs and length of service for wait listed individuals among the various in-home services would remain consistent with the FY 2012 distribution.

	In-Home Service Category	# Served in 2012	% of Total In-Home Services in 2012[14]	# on In-Home Wait List 4th Quarter 2013 (3,568)[15]	Cost per Unit[16]	Average # of Units per Participant[17]	Cost
1	Care Management	3,159	12.27%	438	$326.53	7.49	$1,070,707
2	Case Coordination and Support	8,752	34.01%	1,213	$23.73	7.79	$224,318
3	Chore	3,026	11.76%	420	$23.01	11.95	$115,374
4	Homemaker	6,689	25.99%	927	$13.39	46.52	$577,630
5	Personal Care	4,105	15.95%	569	$16.61	58.17	$549,856
6	Home Delivered Meals	NA	NA	952[18]	$4.34	157.35	$650,119
	Totals	25,731	99.98%	4,519			**$3,188,006**
Inflation Adjustment of 4.323% (includes 2014 - 2.17%; 2015 - 2.151%) = **$137,817**							**$3,325,823**

[13] Source: www.tradingeconomics.com

[14] 2012 Funding Source Distribution (2012 OSA NAPIS Report pg. 7)

Local Program Income	5.4%
Local Matching Funds	20.7%
State Funds	54.2%
Federal Funds	19.6%
Total	100%

[15] Estimated number on wait list for each service was extrapolated by using the total number of individuals receiving service in 2012 divided by the overall number of individuals utilizing all above listed services. The total waiting for service per FY 13 4th quarter wait list data is 3,568 x each service percentage = estimated number waiting per service.

[16] Cost per unit was calculated by dividing the overall service expenditure by the total number of units provided in FY 2012

[17] Average number of units was calculated by taking the total number of units provided per service divided by the total number of participants for each service.

[18] Actual wait list data based upon FY 13 fourth quarter preliminary data from Michigan Aging Information System NAPIS Participant and draft Service Report prepared by Michigan Office of Services to the Aging

It must be noted that wait lists for service is a meaningful indicator of the extent of unmet needs for in-home services, but should not be interpreted to be the sole indicator of unmet need. Wait lists can underestimate unmet need for a variety of reasons:

- Many areas with chronic or excessive wait lists have what is known as wait list fatigue – a situation where applicants and referral sources no longer contact service providers because they know that they will be placed on a long waiting list if they reach out for help, with little hope for receiving services.
- There is significant rationing of services, where participants receive some help, but not as much as is needed, such as only receiving assistance with one bath per week, or one day of adult day care respite per week. On October 1, 2013 63% of Area Agencies on Aging regions reported they had home delivered meal recipients who are underserved in this way, and receive services at levels that are less than the participant's identified need. 69% of the regions reported the same for other in-home services.

PROJECTED UNMET NEEDS RESEARCH

Adults who need help with activities of daily living (ADLs) require assistance with things like bathing, continence, dressing and undressing, eating, toileting, transferring, and walking. Research shows that about 20.7% of older adults who need help with one or more ADL's have an unmet need for assistance. [19] Unmet need is more prevalent among older adults who have difficulty with two or more ADL's. Up to 29% of this group may have an unmet need.[20] Based on this information, there are almost 25,000 older adults in Michigan who have trouble with one or more ADL's and need more assistance than they currently receive[21].

It is estimated that half of all individuals with unmet needs for such assistance are experiencing negative consequences as a result of not receiving the help that they need.[22] Examples of a negative consequence include:

- Discomfort at not bathing often enough
- A burn or scald caused by bathing with water that is too hot
- Discomfort at not changing dirty clothing often enough
- Inability to eat when hungry
- Inability to walk to the bathroom when necessary
- Discomfort or soiled clothing because of inability to get to the bathroom

The study found that because an adequate level of in-home services are not provided to these adults with an unmet need, more than 12,000 of them likely experience one or more of these negative consequences, to the detriment of their health, safety, and well-being.

The most common reasons for having an unmet need for in-home services, according to another study, are lack of awareness of an available service, no services available, discomfort with accepting help from strangers, and a

[19] Desai, M.M., Lentzner, H.R., Dawson Weeks, J. (2001). Unmet need for personal assistance with activities of daily living among older adults. *The Gerontologist 41(1).* 82-88.

[20] LaPlante, M.P., Kaye, S., Kang, T., Harrington, C. (2004). Unmet need for personal assistance services: Estimating the shortfall in hours of help and adverse consequences. *Journal of Gerontology 59B(2)*. S98-S108.

[21] 119,385 adults age 65+ have a self-care difficulty, 119,385*.207 = 24,713

[22] Desai, M.M., Lentzner, H.R., Dawson Weeks, J. (2001). Unmet need for personal assistance with activities of daily living among older adults. *The Gerontologist 41(1).* 82-88.

prohibitive financial cost.[23] In fact, the likelihood of having an unmet need for services increases with multiple ADL difficulties, living alone, increased age, and lower income.[9] Another study found that 25% of all older adults with annual income less than $20,000 reported an unmet need, compared with 15% of older adults with annual income of $20,000 or more.[24] This difference was statistically significant and shows that the lower income population has a greater unmet need for services.

AAA/PROVIDER SURVEY RESULTS

Results of a 2013 survey[25] designed to assess the current state of unmet needs for Office of Services to the Aging in-home services indicate that several years of flat and reduced funding have had significant negative impacts on the ability of Area Agencies on Aging and their network of direct service providers to provide adequate levels of basic services. For the purpose of this survey in-home services include personal care, homemaking, respite, home-delivered meals, chore/minor home repair, care management, personal emergency response systems and medication management. The survey yielded 131 responses from Michigan Area Agencies on Aging, commissions and councils on aging, and other direct service providers.

Key findings regarding unmet need:

- More than 3 out of 4 respondents feel there are not adequate resources to meet the need for personal care (76.1%) and homemaking services (77.1%).
- More than 7 out of 10 respondents feel there are not adequate resources to meet the need for minor home repair (72.3%) and respite services (72.8%)
- The majority of respondents feel there are inadequate resources to meet the need for home-delivered meals (63.8%), medication management (66.3%), care management (59.8%) and personal emergency response systems (50.6%).

Deciding Between Competing Needs: Rationing and Funding Reductions Force Seniors to Make Dangerous Choices

"With reductions in services and increased cost of care we now have to pay 3 times as much privately and are only allowed 10 hours a week of service… This small amount of service does not begin to meet the daily needs I have. If we cannot continue to pay the majority of my care privately I fear my remaining living independently will be greatly compromised." – Ronna, 66

"[Services] keep me independent otherwise I would be in a nursing home. They take me out to shop, take a shower, meal preparation [and] pick up my prescriptions. Since my services were reduced…I have to decide what I need most and things don't always get done." –Darlene 64, Rochester

"[Service level reductions] are really affecting me a lot. My family is not able to help as much as I need. I have to try to find other ways to get help. I spend a lot of time on the phone trying to find out where I can get help." – Lottie 64, Farmington Hills

According to Marie Verheyen, Associate Director for Older Adult Services at Oakland Livingston Human Service Agency seniors can receive either lawn mowing service or snow removal service as there is not adequate funds for both. Seniors who choose lawn mowing service risk being snowed-in. "Unplowed driveways can prevent meals on wheels deliveries, making it to doctors' appointments and seniors who receive their prescriptions by mail risk falls and injuries trying to reach their mailboxes."

[23] Casado, B.L., van Vulpen, K.S., Davis, S.L. (2011) Unmet needs for home and community-based services among frail older Americans and their caregivers. *Journal of Aging and Health 23(3).* 529-553.

[24] Desai, M.M., Lentzner, H.R., Dawson Weeks, J. (2001). Unmet need for personal assistance with activities of daily living among older adults. *The Gerontologist 41(1).* 82-88.

[25] Silver Key Coalition State of Senior Unmet Needs: OSA Funded In-Home Services Survey

Several consequences for older adults have been observed as a result of inadequate service levels. Key findings include:

- 88.4% of respondents have observed less hours of care being provided than is needed with 82.6% reporting observing this in moderate (6-10 instances) to frequent occurrences (11+ instances).

- Over 9 out of 10 respondents have observed at least one instance of social isolation or depression with 83.7% reporting a frequency of moderate (6-10 instances) to frequent occurrences (11+ instances).

- 89.7% of respondents have observed caregiver burnout with 80.5% reporting moderate (6-10 instances) or frequent occurrences (11+ instances).

- 83.7% of respondents have observed a greater likelihood of falls.

- 80.2% of respondents have observed a greater likelihood of inadequate nutrition.

- 81.3% of respondents have observed a greater likelihood of emergency room visits.

- 84.8% of respondents have observed a greater likelihood of costly nursing home placements as a consequence of inadequate levels of in-home services funding or rationing of in-home services.

In addition to the potentially life-altering negative consequences felt by older Michiganians, agencies and service providers are also feeling the pain of budget cuts.

Key impacts on the aging network:

- Nearly 70% of survey respondents reported reductions in staff work hours
- 45.3% reduced the benefit package offered to staff
- 41.5% reduced staff pay
- One out of 3 respondents reported laying off staff members

Results of this survey are validated through similar findings of a 2013 survey conducted by the National Association of Area Agencies on Aging[26] which queried Michigan Area Agencies on Aging regarding the impacts of federal budget cuts. Similarities of note include:

Silver Key Coalition Survey	National Association of Area Agencies on Aging Survey
81.4% of aging network and direct service provider respondents also report significant impacts of reduced funding on their agencies	85.7% of Michigan Area Agencies on Aging report that budget cuts affect their ability to meet the demand for services
76.1% of aging network and direct service provider respondents believe there is inadequate funding levels for personal care services	71.4% of Michigan Area Agencies on Aging report reductions in personal care services as a result of federal funding cuts
68.7% of aging network and direct service provider respondents have reduced staffing hours	50% of Michigan Area Agencies on Aging report reducing staffing levels

[26] Markwood, S., Gotwals, A., & Karkhanis, N. (2013). Squeezing seniors: Aging community fears national crisis as a result of federal budget cuts. National Association of Area Agencies on Aging, Retrieved from http://n4a.org/pdf/n4a_SequesterSurveyReport_FINAL.pdf

Results of these surveys indicate a high level of agreement between both AAAs and direct service providers regarding the inadequacy of the levels OSA in-home services funding and the ability to meet unmet needs of seniors. Resulting from inadequate funding, essential programs that help seniors to live independently have been compromised or even closed.

Serious consequences with potentially life altering effects due to unmet needs are real and have been observed statewide with frequency by survey respondents. These consequences have direct impacts on quality of life and the ability of seniors to remain independent and out of costly alternative living settings.

OSA NEED ASSESSMENTS

In 2012, the Michigan Office of Services the Aging conducted a state-wide needs assessment survey to determine current and emerging needs and service gaps in the state's service delivery system. The survey was made available online and through telephone interviews of residents 50 years and over throughout the state.

Of the age 60+ Michigan residents surveyed, 45% reported having a disability that results in serious difficulty walking or climbing stairs (32.8%), difficulty concentrating, remembering or making decisions (14%) or difficulty doing errands alone such as visiting a doctor's office or shopping (13.6%). Nine percent (9%) had difficulty dressing or bathing as a basic activity of daily living and 13% reported providing care to one or more persons themselves due to injury, disability or long term illness.

Of those age 60+ providing care, 39% are caring for a spouse, 23% are caring for a parent, 16% are caring for a child, 10% are caring for a friend, 8% are caring for an acquaintance and 5% are providing care for a sibling. Seventy-eight percent (78%) of these caregivers are caring for one individual and 13% are caring for two individuals. About 9% are caring for 3 or more persons at one time.

When asked about the type of care being provided, 20% report providing personal care, 20% nursing care and 51% report providing housekeeping assistance. Key difficulties experienced by caregivers are:

- 42% report emotional worries and stress;
- 38% report having to make personal adjustments
- 34% report stress and illness
- 29% report developmental burden experienced through inconvenience and labor intensive support
- 22% report financial strain
- 20% report physical strains from lifting, etc.
- 13% report taking time off work to provide caregiving

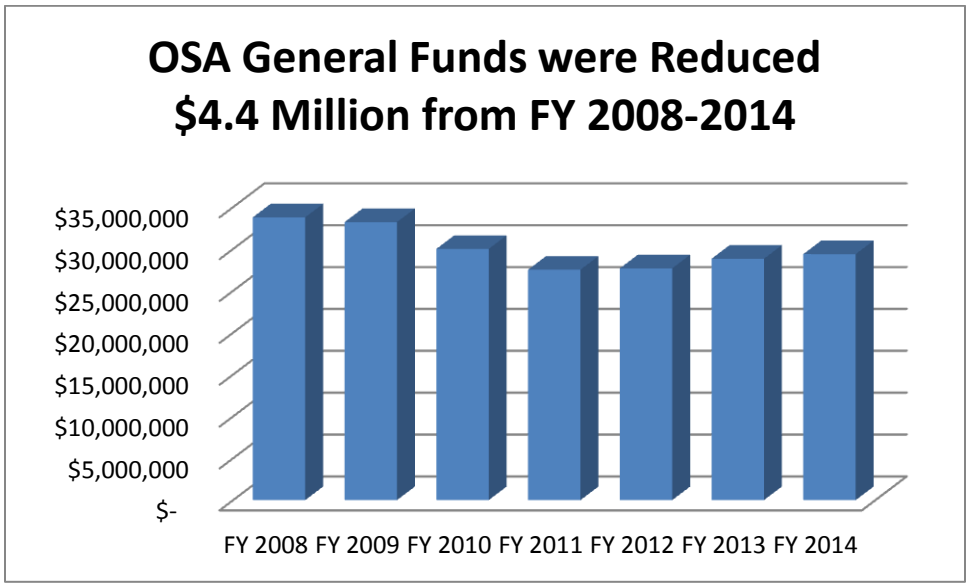
Michigan age 60+ residents report needing help with caregiving and financial strains from trying to pay for it over time.

- 20% need help with activities of daily living such as preparing meals, bathing and housekeeping
- 31% can't find good people
- 50% can't afford to pay for home care for a loved one
- 8% report being on a wait list for home care services

HISTORY OF STATE FUNDING FOR MICHIGAN OFFICE OF SERVICES TO THE AGING

The Michigan Office of Services to the Aging's approved FY 2014 budget totals $94,081,600, with about 63% federal funds, primarily from the Older Americans Act, and 37% from state General and Restricted funds. State General Funds ($29,380,800) constitute 31.2% of the OSA budget and Restricted Funds constitute the remaining 5.8%.

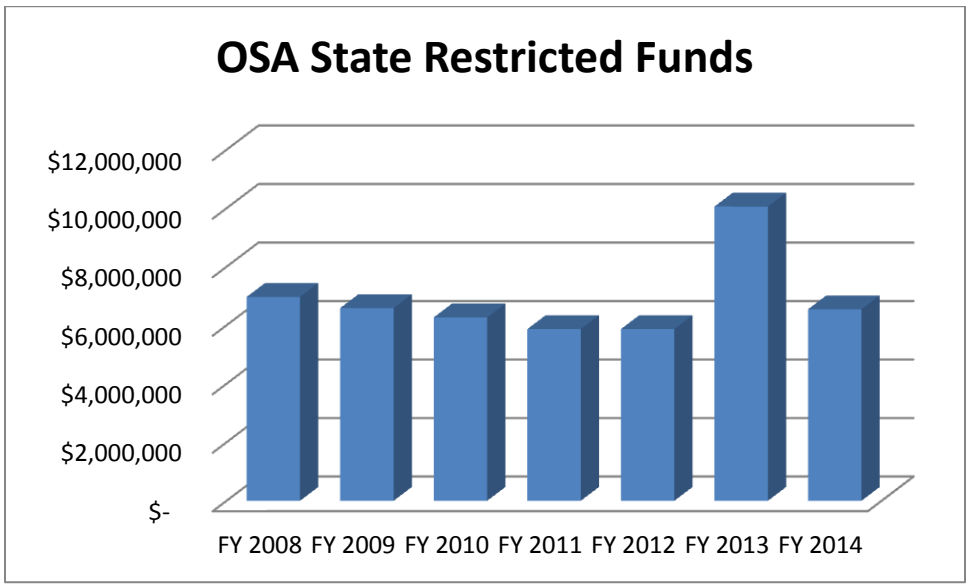
OSA funding for in-home and other services has been under severe pressure from the state and national recessions, the effort to eliminate Michigan's chronic structural budget deficit, and the ongoing effort to reduce federal deficit spending. The chart below shows that OSA has lost $4,398,100 in General Funds since 2008, which represents a 13% reduction. This is despite a $500,000 increase for the senior nutrition program for FY 2014.[27] During this seven year period, Michigan's senior population has increased approximately 13% or over 260,000 individuals.



Restricted Funds

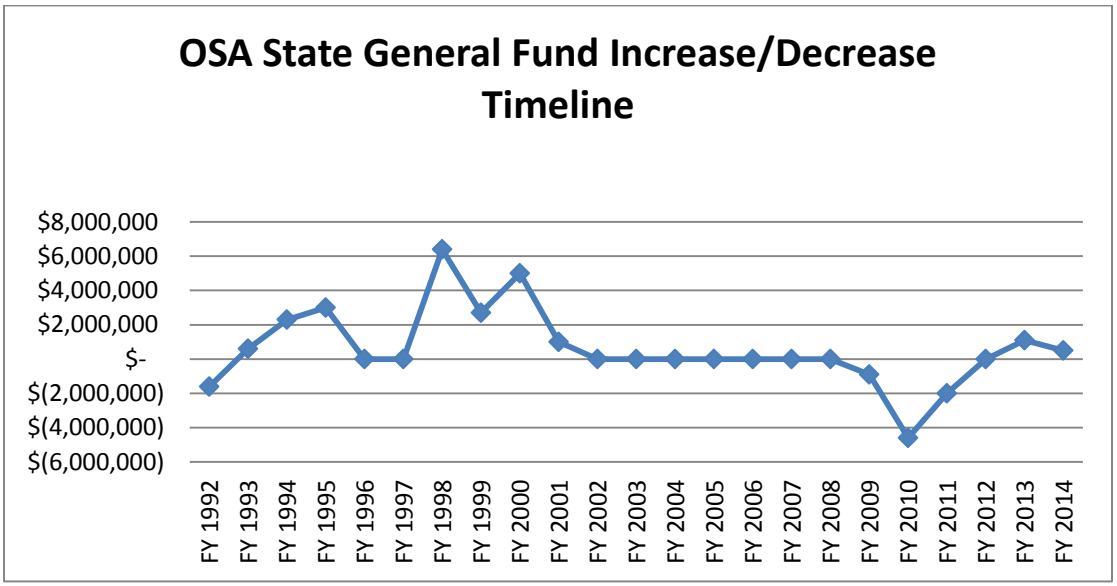
Approximately 18% of OSA's state funding comes from restricted sources, including Merit Trust Funds collected from the tobacco settlement and Abandoned Property Funds from un-cashed health care reimbursement checks that escheat to the state. These funds vary significantly from year to year based on actual revenues collected and policy changes that affect collection and accounting procedures. The table below shows a reduction of $420,800 (6%) in Restricted Funds appropriated between 2008 and 2014. In addition, there was a dramatic 35% loss from FY 2013 to FY 2014 ($3.8 million). This Restricted Fund reduction for respite services, coupled with the federal sequestration-related cuts in FY 2013 and 2014, are expected to increase the number of individuals on waiting lists for in-home services in Michigan.

[27] *Note that this analysis is based on approved fiscal year OSA appropriation bills. Actual allocations may vary based on mid-year adjustments, variations in restricted revenue collections, and past or pending sequestration cuts.*



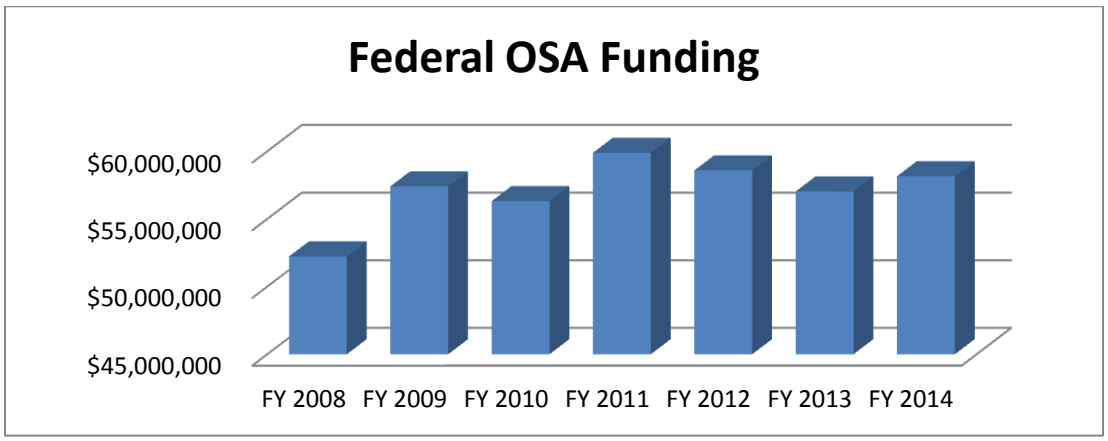
Historical Perspective

The $29.4 million OSA General Fund appropriation is about the same amount of state funding appropriated for OSA in FY 2001. The OSA funding timeline below shows that prior to the 2009 – 2011 period, General Fund allocations either increased or remained the same since FY 1993. Most increases since 1993 have targeted incremental development of Michigan's Care Management program during the 1990s and/or expansion of home delivered meals. The $500,000 increase for FY 2014 is exclusively for home delivered meals.



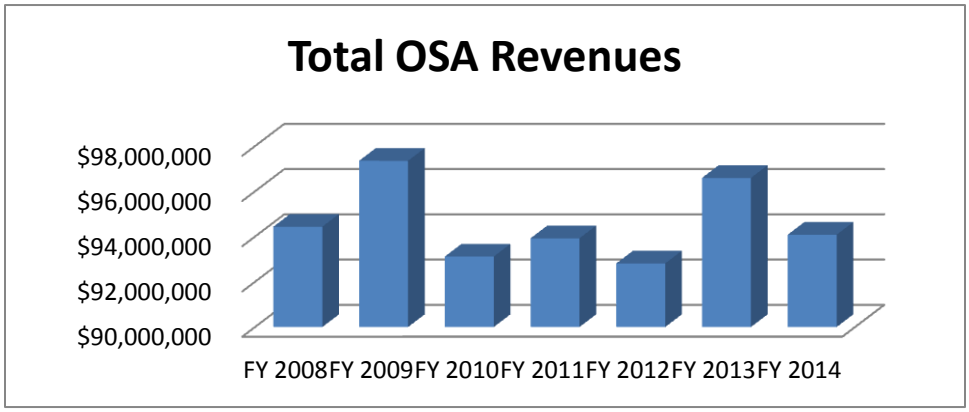
Concurrent Federal Support

Recent federal funding appropriations through the Older Americans Act or Department of Labor (older worker program) have been artificially skewed upward by the onetime increase in economic stimulus funding provided through the American Recovery and Reinvestment Act, which was stretched to last for several fiscal years. The scheduled FY 2014 sequestration cut for Older Americans Act programs has been averted due to approved continuing resolutions and budget agreements, but remain pending for future fiscal years.



Total OSA Funding

When all of OSA's state and federal revenue sources are included, the balance shows an overall decrease in OSA funding from FY 2008 – 2014 of $354,300. While this reduction may not seem dramatic, when increased demand from population growth and inflationary costs are considered over that 7 year period, it has imposed severe hardship. The current reduction from FY 2013 to FY 2014 of $2.5 million has had a significant immediate impact. The January 2014 federal budget deal will provide some yet to be determined relief for the senior nutrition program (includes congregate and home delivered meals), but it maintains the 2013 sequestration cut into 2014, meaning no additional support for other essential OSA programs like personal care, homemaking and caregiver respite.



Michigan's Commitment in Comparison to Other Great Lakes States

A 2011 study conducted by the AARP Public Policy Institute[28] measured the level of state funding supporting state unit on aging programs for all states. Data from that report shows that when measured on a per capita basis for state residents age 60 and older, Michigan is far less generous with state support for senior services than other Great Lakes states. The average allocation of state General Funds by Great Lakes legislatures was $46.69 per state resident age 60 and older. Michigan's per capita allocation was only $14.34, with only Ohio ($3.35) spending less state money on senior services according to this measure. Illinois was the most generous at $123.85.

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[28] **Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports**

by: Jenna Walls, Kathleen Gifford, Wendy Fox-Grage, Rex O'Rourke, Martha Roherty, Lindsey Copeland, Catherine Rudd, from: Public Policy Institute, January 2011

State Unit on Aging Non-Medicaid Home and Community-Based Service Expenditures					
State	FY 2009	FY 2010	2011	2011 State Expenditure per Senior	Age 60+
Michigan			$ 27,000,000	$ 14.34	1,882,954
Ohio	$ 11,557,000	$ 8,060,400	$ 7,477,400	$ 3.35	2,228,884
Indiana	$ 31,900,000	$ 34,800,000	$ 34,800,000	$ 30.04	1,158,470
Illinois	$ 228,420,800	$ 295,914,750	$ 275,662,600	$ 123.85	2,225,761
Pennsylvania	$ 219,673,375	$ 223,649,100	$ 223,649,100	$ 84.58	2,644,174
Minnesota	$ 30,400,000	$ 31,258,000	$ 33,650,000	$ 35.99	935,109
State Average				$ 46.69	
Source: AARP Public Policy Institute					

LOCAL DOCUMENTATION OF UNMET NEED

Detroit

In 2012, the Detroit Area Agency on Aging conducted a series of five Aging Summits throughout its region to examine the needs of older adults, caregivers and service providing agencies through the use of clicker technology. Six hundred and six (606) individuals participated in the community forums and shared their views on keypads. Key findings:

- Sixty-five percent (65%) of participants believe that home care assistance is the most important in-home service to fund followed by in-home respite (19%), friendly visiting (9%) and telephone reassurance. About 4% had other responses.
- 44% of participants support the funding of medical transportation; followed by 19% for both chore services and medication management. Eleven percent (11%) supports the funding of in-home meals.

Calhoun County

In 2013, Calhoun County surveyed approximately 200 individuals from a variety of organizations and agencies throughout the county to identify needs and gaps in the current structure of supports and services available to the older population. The participants told what requests for services they receive from older adults, but did not offer.

- The most common responses were requests for chore services (n=24) and hearing assistance (n=19).
- Respondents ranked transportation and chore services as the greatest unmet needs.
- Respondents overwhelmingly responded that insufficient funding was the number one barrier to providing services, but also that lack of public awareness and transportation were also significant barriers.

St. Clair County

A February 2010 St. Clair County study developed a methodology for projecting the increase in senior service demands for the decade. The model accounted for population changes in seniors living alone, minorities, disability levels, gender, and inflation. The mid-range annual projected increase in demand for senior services was 3.5%. An additional $2 million more than what was available in 2010 for state, federal, and county senior millage funds will be needed to maintain senior services at 2010 levels in 2015.

Case Example: In-Home Services Provide Independence and Save Michigan Money

Office of Services to the Aging (OSA) services are cost-effective preventing seniors from going on Medicaid and costing the state more money.

Eugene* is a 74 year-old, diabetic, double amputee who also suffers from MS-induced dementia. Eugene has been a Care Management service recipient since June of 2007. Care Manager Jillian works with other local community service providers and Medicare skilled care to stitch together the care Eugene needs to be able to stay in the community. OSA funds provide 13 hours per week of respite care to Marilyn*, Eugene's wife and caregiver which enable her to continue in her caregiving role.


Eugene, OSA Care

It is estimated that family caregivers provide 80% of elderly care at no cost to the state. The same is true in Eugene's case. Marilyn provides the bulk of Eugene's care but states that without the supportive service provided by OSA, she could not continue to keep Eugene in their home.

Eugene's level of care needs and their income qualify Eugene for Medicaid funded long-term care service, but their assets are slightly above Medicaid limits. Without OSA services, Eugene would impoverish himself and spend down into Medicaid in a matter of just a few months. This would force Eugene to use Medicaid funded long-term care.

Eugene's care plan costs the state of Michigan $29.11 per day as compared to $172/day for Medicaid funded nursing home care. This is a cost savings of $52,155 per year, every year or a total of $339,007 over the past 6 ½ years since Eugene's services began.

Marilyn and Eugene are very proud individuals. They do not want to rely on Medicaid to pay for Eugene's care. OSA services allow them the dignity of contributing to the cost of Eugene's care, extending AAAs capacity to serve additional seniors.

*Client stories are shared with their permission.

RETURN ON INVESTMENT/VALUE FOR MONEY

LITERATURE REVIEW OF IN-HOME SERVICES OUTCOMES

A review of national literature supported the claim that providing state supported in-home services improves the physical and mental health of frail older adults and prevents costly nursing home admissions.

Services have been shown to impact the following outcomes:

- Depression: Where no informal support was available from non-spouse family or friends, states that provided more support for home and community based services were associated with lower depression rates than states with comparatively less support for services.[29] Also, older adults who were provided services to help them stay in their homes showed lower rates of depression than older adults who were placed in a nursing home.[30]
- ADL (Activity of Daily Living) Functioning: Older adults with services to help them stay in their homes also demonstrated higher levels of ADL functioning, or were better able to independently complete their daily tasks, than those who were in a nursing home.[31]
- Cognition: Staying at home, as compared to placement in a nursing home, was associated with greater alertness, short-term memory, ability to make decisions, ability to make one's self understood, and ability to feed one's self.[32]
- Incontinence: Those older adults who were helped to stay at home had a statistically lower incidence of incontinence than those who were placed in a nursing home.[33]

Additionally, several studies have found a lower risk for nursing home admission among older adults in the community who suffer from cognitive and/or functional impairments and are receiving in-home services than those who are not receiving services.[34] This effect extends to the state as a whole, as one study found that

[29] Muramatsu, M.; Yin, H.; and Hedeker, D. 2010. *Functional declines, social support, and mental health in the elderly: Does living in a state supportive of home and community-based services make a difference?* Social Science & Medicine 70. 1050-1058.

[30] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[31] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[32] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[33] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[34] Luppa, M.; Luck, T.; Weyerer, S.; Konig, H.; Brahler, E.; Riedel-Heller, S. 2010. *Prediction of institutionalization in the elderly. A systematic review.* Age and Ageing 39. 31-38.

"living in a state supportive of [home and community based services] lowers the risk for nursing home admission among seniors."[35]

Other key in-home service outcomes studies are summarized below:

Michigan's expansion of home and community-based services resulted in the state's first ever decline in nursing facility expenditures[36]

Michigan is one of 10 states that received a CMS grant under the Real Choice Systems Change program to develop a profile of the state's publicly funded LTSS. The profile presented in this report includes an overview of demographics and projected LTSS demand; service utilization; a description of the infrastructure and capacity needs; and initiatives and progress toward reforming the system to increase HCBS options. The report notes that expenditures and LTSS days in nursing facilities declined for the first time in FY 2008 because of balancing efforts. The state legislature increased HCBS funding beginning in FY 2006.

Older Americans Act/State Unit on Aging services delay nursing home entry and results in state cost avoidance [37]

The report summarizes four studies completed under the Administration on Aging's (AoA's) Advanced Performance Outcomes Measure Project (POMP) grant to assess the impact of AoA programs in a manner that can be associated with cost. The analysis addresses the demographics, client program and service data, and client functional and clinical assessment data to determine the impact on older adults. In addition, a qualitative analysis helps to clarify findings in the quantitative studies. The report concludes that individuals residing in a nursing home who received State Unit on Aging (SUA) services prior to their entry are older on average than individuals residing in a nursing home that did not receive SUA services; and the services delay entry into a nursing home on average by 17 months for all clients, and by 23 months for clients at high risk. In addition, the highest risk factors for SUA service recipients include caregiver proximity, client age, and client mental status. Although the report notes that costs were avoided by comparing the average cost per month for nursing home clients with an average cost of SUA services for basic, intermediate, and high-intensity services, more analysis is needed to determine the specific (non-average) annual cost avoidance savings.

[35] Muramatsu, M.; Yin, H.; and Hedeker, D. 2010. *Functional declines, social support, and mental health in the elderly: Does living in a state supportive of home and community-based services make a difference?* Social Science & Medicine 70. 1050-1058.

[36] Michigan Department of Community Health, Office of Long-Term Care Supports and Services; "Michigan Profile of Publicly-Funded Long-Term Care Services"; June 2009. Accessed December 2012 at: http://www.michigan.gov/documents/ltc/SPT_Final_ Report_7-01-09_300163_7.pdf.

[37] Rhode Island Department of Elderly Affairs (DEA); "Preliminary Findings: Summary of DEA Services Impact on the Entry of Clients to Rhode Island Nursing Homes"; December 31, 2009.

Longitudinal study finds home and community-based services for those at risk of entering nursing homes resulted in a 23.8% reduction in overall Medicaid expenditures and returned on investment of $2.92 for every dollar invested.[38]

Researchers studied the effectiveness of the Arkansas Community Connector Program (CCP), a Medicaid demonstration program in three counties that targets individuals at risk for entering nursing homes and links them with appropriate community-based services and supports. They tested the hypothesis that the CCP participants experienced larger growth in the use of and spending for Medicaid HCBS, and smaller growth in overall Medicaid spending, compared with the comparison group. Expenditure measures included inpatient and outpatient medical services, nursing home services, HCBS, and other services. The longitudinal study spanned 3 years of intervention, plus 1 year before and after the intervention, for both the intervention group and a statistically matched non-intervention group. Researchers determined the result of the intervention was a 23.8 percent average reduction in annual Medicaid spending per participant during the 3-year period. Net savings equaled $2.619 million for the 919 individuals included in the study's intervention group, or a return on investment of $2.92 per dollar invested in the program.

Seven year look back analysis long term care service costs for nursing home residents finds overall spending for those who received home and community-based services to range between $1,000 and $1,500 per month less than for those who were on wait lists and never received in-home services before entering a nursing home[39]

This analysis built on prior work of the authors to determine whether HCBS is cost effective. The researchers obtained cost and assessment data for individuals residing in nursing homes who were placed in three study groups: 1) individuals who had applied for and received HCBS; 2) individuals who had applied for but did not receive HCBS (waitlist); and 3) individuals who did not apply for or receive HCBS. The longitudinal study spanned service years from 2002 through 2008. The authors presented evidence that HCBS utilization produces cost savings compared with costs of individuals that do not use these services, most notably in a reduction of nursing home expenses. Nursing home cost savings associated with HCBS use ranged from $1,000 to $1,500 per member per month compared with non-HCBS applicant utilization, depending on HCBS use intensity. The authors incorporated both Medicaid and non-Medicaid LTSS in assessing overall cost effectiveness.

[38] Holly C. Felix, Glen P. Mays, M. Dathryn Steward, Naomi Cottoms, and Mary Olson; "Medicaid Savings Resulted When Community Health Workers Matched Those with Needs to Home and Community Care"; Health Affairs 30, no. 7 (2011): 1366–1374. Accessed December 2012 at: http://content.healthaffairs.org/content/30/7/1366.full?ijkey=zrqbtjW.Gr7NQ&keytype=ref&siteid=healthaff.

[39] Adam Shapiro, PhD; Chung-Ping Loh, PhD; "Advanced Performance Outcome Measures Project (POMP): Estimates of Medicaid and General Revenue Cost-Avoidance from HCBS Utilization"; University of North Florida; August 2010. Accessed April 2012 at: http://www.gpra.net/ppt/POMP2010_UNF_Final_Report.pdf.6

Individuals receiving Care Management found to have improved access to physician services, lower emergency room use, resulting in cost savings.[40]

The purpose of this evaluation was to determine the impact of Rhode Island's Global Waiver on Medicaid expenditures. Three areas of interest were evaluated:

1. The impact of LTSS delivery changes on enrollment, utilization, and cost of services and supports for older adults and adults with disabilities in HCBS settings and in institutions;
2. The effect of care management initiatives on Medicaid cost and health outcomes; and
3. Progress toward state efforts to ensure "the right services, at the right time, in the right setting."

The evaluation concluded that the Global Waiver was successful in balancing the LTSS system to greater reliance on HCBS with estimated savings of $35.7 million over the 3-year period. In addition, an analysis of medical services utilization found improved access to physician services and lower emergency room use by individuals receiving care management, for estimated savings of about $5 million in FY 2010, including individuals with disabilities and those with mental health disorders or chronic conditions. Findings were based on analysis of data pre- and post-implementation of the waiver, and through comparing costs to those in traditional fee-for-service delivery.

Brown University study finds home delivered meals to be the only statistically significant factor among Older Americans Act programs that affected state-to-state differences in low-care nursing home population. [41]

Brown University documented the positive impact of increased spending on home-delivered meals programs for older adults. The study compared state-level expenditures on Older Americans Act (OAA) programs with the population of "low-care" seniors in nursing homes (i.e., residents of nursing homes that might not need the suite of services that a nursing home provides). According to the analysis from a decade of spending and nursing home resident data, states that invest more on home-delivered meals to seniors have lower rates of "low-care" seniors in nursing homes.

Major findings from the Brown study include:

- Home-delivered meals emerged as the most significant factor among OAA services that affected state-to-state differences in low-care nursing home population.
- For every $25 per year per older adult above the national average that states spend on home-delivered meals, they could reduce their percentage of low-care nursing home residents compared to the national average by one percentage point.

The Brown study included state spending on OAA programs and information from each state between 2000 and 2009 as well as a variety of public health and nursing home data sources compiled by Brown University's Shaping Long-Term Care in America Project. In all, 16,030 nursing homes were included in the research.

[40] The Lewin Group; "An Independent Evaluation of Rhode Island's Global Waiver"; December 6, 2011. Accessed December 2012 at: http://www.ohhs.ri.gov/documents/ documents11/Lewin_report_12_6_11.pdf

[41] Kari Thomas and Vincent Mor, Health Services Research, November 2012

Time-To-Event study finds significant reduction in nursing home placement risk for those who receive higher level of Older Americans Act services supported through the State Unit on Aging[42]

The evaluation used time-to-event analysis (e.g., time to nursing home placement) to determine whether the use of Older Americans Act (OAA) services serve to delay nursing home placement. Two sets of data from the Department of Elderly Affairs spanning different periods (December 1998 through December 2005; and January 2005 through September 2007) were used to conduct the analysis. The authors conclude that a statistically significant reduction in risk for nursing home placement is associated with increased number of OAA services received, controlling for demographics and functional status. No single type of service contributed directly to the decreased risk, but the total program of services was important to reducing risk.

IN-HOME SERVICE WAITING LIST OUTCOMES STUDY

In 2011 the Area Agency on Aging 1-B, in collaboration with Dr. Louanne Bakk, University at Buffalo, conducted a longitudinal analysis of the outcomes for individuals who were placed on the AAA 1-B wait list for in-home services in 2008, and what happened to them after two years. Outcomes measured included mortality, nursing home admission, relocation, hospital admission, emergency room visits, and caregiver well-being, with outcome predictions for each category.

The longitudinal research[43] on the impact of in-home service wait lists produced evidence that individuals on wait lists who do not receive services have poorer outcomes than those who were on the wait list but eventually received services. The comparison of these two groups found that while there is a cost to providing services to those on a wait list, these costs are mostly offset by a savings in reduced health care utilization that is predictable. For example, those receiving service have a 20% greater chance of living in their own home two years after going on a wait list, than those who did not receive service. A cost savings ratio was constructed that factors in health care utilization and the impact on communities is assessed and quantified.

Methodology

1,471 individuals were placed on the AAA 1-B MI Choice and Care Management wait list in 2008. Approximately two years later, efforts were made to determine their status. Of the 1,471 individuals, 769 (52.28%) were contacted and interviewed (mostly caregivers). Intake records were reviewed to assess health and demographic information for all 1,471. It was determined that 441 had died and 273 were alive and living locally.

[42] Dwight B. Brock, PhD; Beth Rabinovich, PhD; Jacqueline Severynse, BS; Robert Ficke, MA; "Risk Factors for Nursing Home Placement Among OAA Service Recipients: Analysis of Two Data Sets From the Rhode Island Department of Human Services"; Westat; U.S. Administration on Aging Contract No. 233-02-0087.

[43] In addition to the measures contained in the survey, variables providing health and demographic information for each respondent were obtained from the AAA 1-B Universal Intake report and merged with the survey dataset. All univariate, bivariate, and multivariate statistics were conducted in Stata version 12.0. Significance in bivariate and multivariate analyses were tested at the $p<.05$ level.

Key Findings

- When contacted, about 70% were still waiting to receive MI Choice or Care Management and 30% were receiving services.
- Of those receiving services, 76% were still living in their own home, while only 57% of those still waiting for service remained in their own home.
- Those not receiving service were more than five times more likely to be living in a nursing home (4% vs. 22%).
- 84% of those who did not receive service and moved to a nursing home did so because the care receiver's needs exceeded the capacity of their caregivers, while only 33% of those who received services moved to a nursing home for the same reason.
- Of the 33 individuals whose caregiving needs exceeded their caregivers' capacity, 97% were not receiving AAA 1-B services.
- For caregivers who were still working, 76% of those not receiving services said the caregiving responsibility interfered with the caregiver's employment, while only 24% of employed caregivers receiving services stated caregiving interfered with their work.
- Of employed caregivers whose employment was negatively impacted by their caregiving responsibilities, those not receiving AAA 1-B services were five times more likely to suffer a financial loss (i.e. quit work, reduce hours, etc.).
- The state can save $964,000 annually by providing OSA/OAA services for every 100 individuals on in-home service waiting lists. This is because:
    - The typical annual average long term care cost to taxpayers for publicly supported services for 100 wait listed individuals who need in-home services is $1.38 million (Medicaid cost for 22 individuals expected to move to nursing home ($172/day, $0 for the 78 others).
    - The typical annual average cost to taxpayers for publicly supported services for 100 wait listed individuals who receive OSA in-home services ($4.74/day) is $416,000 (OSA cost for 96 individuals of $165,000, plus nursing home cost for 4 individuals of $251,000)
    - The public savings represents the difference between the expense for the 100 individuals not served ($1.38 million) minus the cost of serving all 100 individuals ($416,000) - $964,000

The study concluded that Michigan taxpayers would benefit from a net savings of $964,000 in state taxes to support every 100 individuals on the in-home service waiting lists by providing access to in-home services. The survey sample included those on MI Choice and non-Medicaid OSA in-home service wait lists.

RETURN ON INVESTMENT FOR IN-HOME SERVICE FUNDING

The economic impact of state funds allocated for Michigan Office of Services to the Aging (OSA) in-home services are significant and magnified by the ability of these funds to:

1. Generate local matching contributions by participants and local governments and charities;
2. Create an economic return to taxpayers through job creation, and tax revenue generation; and
3. Provide services at below market rates due to volume and value purchasing.

The return on investment for every $1 million in state funds allocated generates:

- Between $354,300 (in-home care) and $488,100 (meals) more in local matching contributions
- Between $68,000 (in-home care) and $75,000 (meals) in state tax revenue
- 40 – 44 new jobs created
- Saves taxpayers and homebound older adults between $230,000 (homemaking) and $352,000 (personal care) for in-home care and at least $491,000 for home delivered meals over private market rates

A 2010 study by Dr. Yong Li, Assistant Professor, Department of Public Health, Indiana University[44] quantified the economic "multiplier effect" of MI Choice funding as those dollars ripple through the state's economy by using the Regional Input-Output Modeling System (RIMS II) developed by the US Bureau of Economic Analysis. MI Choice is a Medicaid home and community-based services program that assists older adults and adults with disabilities who have nursing facility level of care needs to remain living independently in a community setting. The vast majority of MI Choice service expenditures are the same as OSA in-home services, such as personal care, homemaking, home delivered meals, caregiver respite, etc. The study utilized RIMS II to calculate the impact of home and community-based services on job creation and tax dollars returned to the state.

Leveraging Additional Contributions

The table below utilizes 2012 NAPIS data to demonstrate the leveraging impact that state in-home services funding has on generating additional local contributions toward service expenditures. Home delivered meals funding leveraged an additional 48.81 cents to purchase services for every dollar allocated, and the other in-home services leverage an additional 35.43 cents per dollar. This means that for every $1 million funding increase, an additional $354,300 will be raised for in-home services (excluding meals) and an additional $488,100 will be raised to purchase additional home delivered meals.

	AMOUNT LEVERAGED BY $1 MILLION IN STATE FUNDS					
	Total Expenditure	**Local Expenditure**	**Local Expenditure Rate**	**State Expenditure**	**Local Percent Leveraged**	**$1 Million Leveraged Total**
In-Home Services	$ 18,383,829	$ 4,809,433	26.10%	$ 13,574,396	35.43%	$ 1,354,300
Home Delivered Meals	$ 33,681,037	$ 11,047,380	32.80%	$ 22,633,657	48.81%	$ 1,488,100

[44] Dr. Yong Li, Assistant Professor, Department of Public Health, Indiana University, Economic Impact of the MI Choice Medicaid Waiver Program, July 2010

Tax Revenue Creation

The table below demonstrates how leveraged in-home services funding creates a direct dollar return to state government by applying the "multiplier effect" calculated by Dr. Li (5.08%) to three levels of in-home service allocations. Every $1 million allocated by the Michigan Legislature for home delivered meals has a net cost of only $924,405, and the net cost for other in-home services is only $931,212. This is because the Dr. Li study found that each dollar allocated returns 5.08% in tax dollars to state government through various taxes and fees.

	AMOUNT RETURNED IN STATE TAXES AND FEES				
	$1 Million State Leveraged Total	**State Tax Return Rate per $1 Million**	**State Tax Return per $1 Million Allocated**	**State Tax Return per $5 Million Allocated**	**State Tax Return per $10 Million allocated**
In-Home Services	$ 1,354,300	0.0508	$ 68,798	$ 343,992	$ 687,984
Home Delivered Meals	$ 1,488,100	0.0508	$ 75,595	$ 377,977	$ 755,955

Job Creation

Dr. Li's study found that for every $34,030 in state funding allocated for in-home services, one new job is created. Based on this finding and the capacity of state funds to leverage additional resources, every $1 million in state funding creates 40 – 44 new full time jobs.

	State Expenditure	**Local Percent Leveraged**	**$1 Million Leveraged Total**	**Job Creation per $1 Million after Leverage**	**Job Creation per $5 Million**	**Job Creation per $10 Million**
In-Home Services	$ 13,574,396	35.43%	$ 1,354,300	40	199	398
Home Delivered Meals	$ 22,633,657	48.81%	$ 1,488,100	44	219	438

Value for the Money

A 2013 survey conducted by the Area Agency on Aging 1-B (AAA 1-B) in southeast Michigan found that state subsidized personal care and homemaking services are purchased on behalf of older adults and adults with a disability through the "Aging Network" at a cost to taxpayers that is 17% to 26% below private market rates. The power of leveraging and value purchasing means the total savings ranged from the report[45] concluded that if all regions of the state purchase personal care and homemaking at the discount level that the AAA 1-B receives, the annual savings to the state and taxpayers is approximately $2.3 million for Michigan Office of Services to the Aging in-home service programs and $35 million for the MI Choice program.

A 2011 market survey of home delivered meal options available for purchase by private market sources found that meals delivered through the Michigan Office of Services to the Aging program cost 33% to 42% less to

[45] Personal Care and Homemaking Services for Older Adults and Adults with a Disability: The Value and Outcomes for Consumers, Caregivers, and Public Funders, April 1023, Area Agency on Aging 1-B. Findings based on 2011 negotiated rates and a secret shopper rate survey.

prepare and deliver.[46] This efficiency means that with leveraging, taxpayers save at between 48 cents and 62 cents on every dollar allocated for home delivered meals over what the homebound elderly would pay if they were to purchase home delivered meals from private companies such as Jenny Craig at Home, Seattle Suttons, or Mom's Meals.

	DOLLARS SAVED PER $1 MILLION OF STATE FUNDING		
	$1 Million Leveraged Amount	**Negotiated Discount Below Private Market Rates**	**Dollars Saved per $1 Million Allocation**
In-Home Services			
• Personal Care		26%	$352,000
• Homemaking	$ 1,354,300	17%	$230,000
Home Delivered Meals	$ 1,488,100	33% - 42%	$491,000 - $625,000

ECONOMIC AND COMMUNITY DEVELOPMENT IMPACT OF IN-HOME SERVICES

The demand and impact of in-home services is dramatically represented in its creation of both jobs and small businesses associated with the Michigan industry. Increasing state funding of in-home services will create and strengthen small businesses and jobs.

For local communities struggling to create meaningful employment opportunities and grow their private-sector economies, in-home services jobs are a critical foundation on which to build. The sector provides an array of jobs with modest to more intense educational requirements, creating career ladders that allow people to increase their income and advance skills and opportunities in health services, business, and management.

A survey conducted by the Office of Services to the Aging (OSA) of the 500+ small businesses across the state that deliver in-home services to the state's elders found these employers are a stable and growing part of Michigan's economy. With as many as 300 employees, these in-home services businesses have an average staff size of about 50 employees--largely aides but also nurses and office staff in almost every county. The majority of these businesses are generally locally owned as a standalone "mom and pop" business or a locally owned franchise of a national private duty company.[47] A substantial number of these employers are parts of county government, particularly in rural parts of the state. According to the U.S. Bureau of Labor Statistics[48], the number of Michigan in-home services businesses grew over 40% between 2006 (1102) and 2010 (1556) demonstrating the economic avenues for business ownership created by the industry.

In addition to being a way to stimulate business growth locally and statewide, the in-home services industry is also a job creator. Michigan's Labor Market Information (MLMI) reports that the state's two fastest growing occupations are home health aides (58%) and personal services aides (42%).[49] Both occupations are essential in the delivery of in-home services.

[46] The Value and Outcomes for Michigan's Home Delivered Meals for the Elderly Program, May 2011, Area Agency on Aging 1-B

[47] "Findings from a Survey of MI Choice Provider Organizations: Understanding Michigan's Long-Term Supports and Services Workforce," March 2013, located at www.phinational.org/michigan/workforcesurveys.

[48] U. S. Bureau of Labor Statistics, www.bls.gov Analysis found at www.phinational.org.

[49] Michigan's Labor Market Information. www.milmi.org

MLMI projects that almost 25,000 new jobs in these occupations will be created by 2020 across the entire state. Jobs in this sector have grown and are growing at four times the rate for the overall economy even during in the depths of the Great Recession.

And, these jobs will remain parts of our states' economy. It is highly unlikely that these "high touch" jobs can be replaced by technology or outsourced to other states or countries. These jobs will continue to be performed by caregiving hands and trained minds of the people who live in this state.

And, finally, in Michigan and other states, in-home services jobs are growing at a rate faster than hospital or nursing home jobs.[50] This transition follows the private sector payer and state and federal governmental incentives to decrease admissions, the length of stays, and re-admissions to hospitals, the most expensive setting for health services. Economically, health care services are moving away from all health facilities and into the homes of people needing health care services.

IMPACT OF IN-HOME SERVICES ON FAMILY AND INFORMAL CAREGIVERS

It is commonly reported that between 80% and 90% of caregiving in the U.S. is performed by family or other unpaid caregivers. AARP investigated this issue and found that 1,280,000 Michigan caregivers perform 1,380,000,000 hours of caregiving each year. This means that about 13% of the total state population are caregivers for a friend or family member (all ages) for an average of 1,078 hours per year or 20.7 hours per week.[51],[52]

Who are the caregivers?

In 2012, Michigan's Office of Services to the Aging reported the following characteristics of caregivers who benefit from state-supported in-home services for seniors with activity of daily living and independent activity of daily living limitations in Michigan[53]:

- 70% are female
- 53% are over the age of 65
- 45% reside in rural areas
- 28% are low-income
- 24% are minority by race and/or ethnicity
- 35% are employed full or part-time.

[50] For national data: Bureau of Labor Statistics, Employment Projections Program, 2012-2022 Employment Matrix. www.bls.gov. For Michigan: Michigan Department of Technology and Management and Budget, Labor Market Information, 2008-2018 Long-Term Employment Projections. www.milmi.org.

[51] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[52] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

[53] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

Of all caregivers in the U.S.,

- More than one third of caregivers have a child or grandchild living with them[54]
- 43% have completed college
- 42% report household income less than $50,000

Who do caregivers take care of?

Of caregivers over the age of 60 in Michigan,

- 39% are caring for a spouse
- 23% care for a parent
- 16% care for a child
- 13% are caring for two individuals and 9% are caring for three or more individuals at one time

What kind of care do caregivers provide?

Caregivers across the U.S. spend the majority of their caregiving time (an average of 20.7 hours per week in Michigan) providing assistance with at least one Activity of Daily Living (ADL). This usually takes the form of helping the person get in and out of beds and chairs, get dressed, bathe or shower, get to and from the toilet, deal with incontinence, and/or helping to feed the person. [55]

Caregivers in Michigan report the following about their caregiving situations:

- 67% provide daily, hands-on care
- 51% provide housekeeping assistance, 20% provide personal care, and 20% provide nursing care
- 55% live with the person that they cared for, and 38% travel up to an hour to provide care
- 42% indicate that there were "no other family members willing or able" to help provide care
- 72% have been caregiving for more than one year, and 49% for three or more years
- Caregivers over the age of 65 are more likely than their younger counterparts to be the sole unpaid caregiver for the care recipient[56]
- 8% report being on a wait list for home care services.

How are caregivers affected by their caregiving role?

The nature and extent of the caregiving work, while rewarding, can cause significant strain and stress to the caregiver and negatively impacts their health and daily lives in many ways.[57]

- Almost one third of caregivers in Michigan (29%) described their health as "fair" or "poor."[58]
- Nationally, worsening health is particularly present in caregivers who are high burden, co-resident caregivers, women, and those providing more than 21 hours of care per week. [11]

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[54] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

[55] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

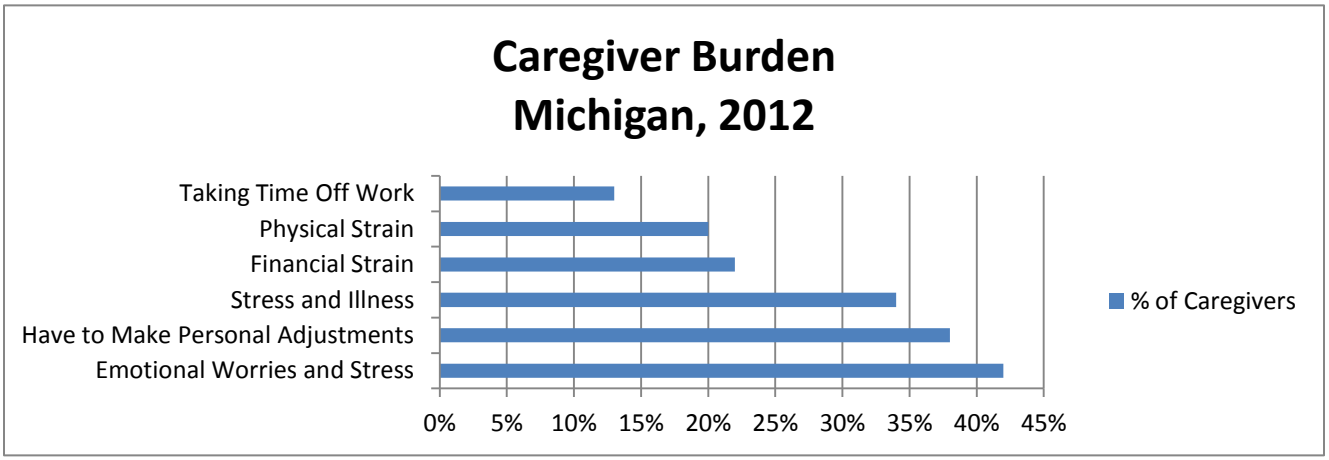
[56] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

[57] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

[58] 2012 Caregiver Information. Michigan Office of Services to the Aging.

- 31% of U.S. caregivers consider their caregiving to be emotionally stressful. 42% of Michigan caregivers report emotional worries and 34% report stress and illness.[59] National research supports the assertion that caregiver stress can result in increased risk of illnesses such as colds and flu, and chronic diseases such as heart disease, diabetes, and cancer. [60]
- Stress also causes increased morbidity and mortality.[61] Spouses who experience mental or emotional strain due to their caregiving responsibilities have a 63% higher risk of dying than non-caregivers, according to a national study.[13]
- Half of U.S. caregivers say their caregiving takes time away from friends and other family members. [11]
- 22% of Michigan caregivers report a financial strain due to their caregiving responsibilities.[62]
- The average family caregiver for someone 50 years or older spends $5,531 per year on out of pocket caregiving expenses, more than 10% of the median income for a family caregiver.[63]
- Six out of ten caregivers who reported an increase in their spending on care also reported having difficulty paying for their own basic necessities.[64]
- More than 70% of U.S. caregivers were employed at some point when they were caregiving, and two thirds of them have gone in late, left early, or taken time off of work because of caregiving issues. [65]

Table[66]



[59] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

[60] *Family Caregiver Fact Sheet.* Caregiver Resource Network. <www.caregiverresource.net.>

[61] *Caregiver Health.* American Medical Association. <www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/caregiver-health.page.>

[62] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

[63] *Valuing the Invaluable: The Economic Value of Family Caregiving,* 2008 Update. AARP.

[64] *Evercare Survey of the Economic Downturn and its Impact on Family Caregiving,* March 2009.

[65] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[66] 2012 Caregiver Information. Michigan Office of Services to the Aging.

ECONOMIC IMPACT OF CAREGIVING

The national economic value of caregivers' contributions exceeds Medicaid spending for long-term care, which includes both nursing home care and home and community-based services. Compared to the value of existing home and community-based services alone, the economic value of family caregiving could be up to 30 times as great. AARP states that, "family members and friends are the backbone of long-term care in all states,[67]" and Michigan is no exception.

Michigan businesses also have an economic stake in supporting caregivers. According to MetLife, American businesses can lose as much as $34 billion each year due to employees' need to care for loved ones 50 years of age or older.[68]

HOW DO IN-HOME SERVICES HELP CAREGIVERS?

Research shows that supportive services can help to reduce caregiver stress and delay or even prevent the institutionalization of the care recipient[69], providing a real value to family and other unpaid caregivers. AARP recommends the following policies and programs to support caregivers and ease their burden:

1. Information and referral to services
2. Assessment of caregivers' own needs, including their health status
3. Respite services
4. Tax incentives to help offset direct expenses.

As other sections of this paper demonstrate, providing adequate in-home services for persons with disabilities and more help for family caregivers can be achieved at a small fraction of the value that caregivers already provide in Michigan. As AARP states, "supporting family caregivers is sound fiscal policy.[70]"

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[67] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[68] *MetLife Caregiving Cost Study: Productivity Losses to U.S.* MetLife Mature Market Institute and National Alliance for Caregiving Business. July 2006.

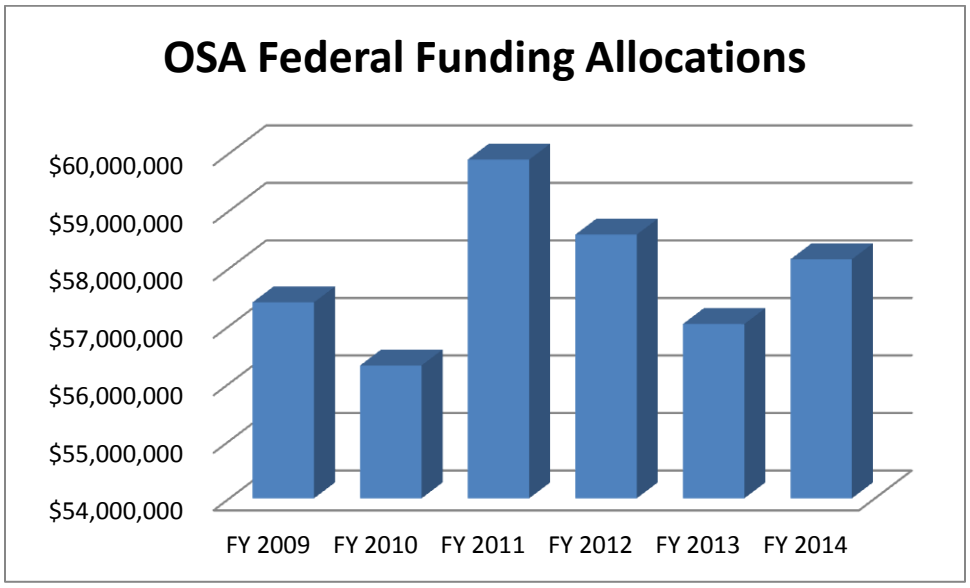
[69] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[70] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

OTHER FACTORS IMPACTING MAKING MICHIGAN A NO WAIT STATE FOR IN-HOME SERVICES

OUTLOOK FOR FUTURE FEDERAL FUNDING

Federal appropriations for the Michigan Office of Services to the Aging through the Older Americans Act has been essentially level funded since 2009, and is at significant risk of cuts due to Congressional intent to reduce deficit spending. The table below demonstrates minor variations in funding, with the FY 2014 allocation an estimate that will likely not be finalized until late spring due to congressional Continuing Resolutions and a delay in approving a federal budget until January 2014.



The main factor looming over the prospects of future federal funding is how Congress manages the mandated deficit reduction measures and sequestration that were imposed by the Budget Control Act of 2011 (BCA). The BCA mandates that a ten year savings of $1.2 trillion is achieved by cutting $109 billion each year. If Congress does not agree on how this deficit reduction is achieved, an automatic cut, called sequestration, will be implemented. The first such cut was implemented in FY 2013 through mandatory cuts split equally between defense and non-defense discretionary programs. (Mandatory spending such as for programs like Medicare, Medicaid and Social Security are excluded.) The Michigan Office of Services to the Aging was cut by $2,270,540[71] due to sequestration in FY 2013. For FY 2014 the cut for senior nutrition programs was mostly restored, but the cuts to other older adult programs were sustained. Absent further Congressional action the Michigan Office of Services to the Aging faces the prospect of future Older Americans Act reductions as its share of the $109 billion in annual cuts for FY 2015 through 2022.

[71] This comes from the Estimated Federal Sequestration Reductions on FY 2013 AoA Formulary Grants to OSA table. Personal communication with MI Office of Services to the Aging.

FUTURE FUNDING OUTLOOK FOR SENIOR MILLAGES

At least sixty-five Michigan counties have voter approved county-wide senior property tax millages that raise over $60 million in local dollars to support a variety of senior services. These senior millages have been hit hard with losses due to property value declines in recent years and are just now starting to recover part of their lost funding. However, the recovery is at risk due the potential loss of another $1.2 million to $2 million that could result from the planned reduction in Michigan's Personal Property Tax (PPT).

Background[72]

On December 27, 2012, the Governor signed a series of new laws that reduce property taxes levied on personal property, and provide mechanisms to potentially replace a portion of the lost tax revenue. The exemption of PPT for commercial and industrial property is widely seen as necessary to keep Michigan competitive in attracting and retaining business, and the PPT is acknowledged to be both outdated and burdensome to administer for both the taxing units and the business entities.

Recognizing the financial impact upon Michigan's cities, counties, schools, and myriad other local entities which have received this relatively stable source of funding for many years, the Governor, and legislature sought methods to replace a substantial portion of the revenue loss. Initially proposed to come from annual general fund appropriations with income from expiring tax credits, local communities balked at that method's vulnerability to the uncertainty of the annual appropriation process, preferring a more stable and reliable mechanism.

The proposed solution in the new legislation was the creation of a Metropolitan Areas Metropolitan Authority (MAMA) under PA 407 of 2012. While the MAMA will handle other duties, the primary function of the new Authority will be to levy a local use tax authorized under PA 408 and to distribute the revenue to local units. Reimbursements to local units will be determined by formulas within the Act.

As required by PA 408, there will be an August 2014 statewide ballot which will include the question of whether to approve a local use (sales) tax levy by the MAMA. If approved, the State's 6.0% use tax rate will be lowered by the amount of the use tax levied by the MAMA. The rate of the use tax levied by the MAMA will be determined by the amount of revenue that the tax may generate. Revenue from the local use tax is required to be solely, and completely, spent on reimbursements to local units eligible for distributions under PA 407. The revenue from the local use tax will reduce the State's share of use tax revenue that is directed to the General Fund. Expiring tax credits will then backfill the state's use tax loss.[73]

There is considerable concern among the local governmental units and legislators that the ballot initiative may not be well understood and because it deals with taxation, could fail. In that case the PPT exemptions will be repealed. The worry is that the legislature could then pass new legislation authorizing the PPT exemptions with either no replacement revenue or go back to the annual appropriation methodology.

[72] This background and analysis is drawn mostly from the preliminary estimates of the Michigan Directors of Services to the Aging Advocacy Committee 2013 report.

SENIOR MILLAGE

The initial PPT proposal called for 100% replacement for "voter approved millages," while other entities were to be reimbursed at 80%. As the legislation wended through the process, only schools and intermediate school districts were provided 100% protection from PPT losses. That comes in the form of 100% replacement as the first funds out of the MAMA revenue. Although the intent was to reimburse other entities (Including senior millages) at 80%, there is no guarantee that adequate funds will be available to that level. In addition, the law is silent on the replacement distribution mechanism on the local level, leaving a concern about who would have the authority to decide on local distribution amounts among the taxing units.

Potential Impact on Local Senior Programs

Because counties vary widely in the extent of their industrial and commercial business base, there will be some communities which will be minimally impacted by the PPT exemptions, while others will experience significant revenue loss. It is estimated that when the PPT exemptions become fully effective, senior programs will lose between $1.5 and $2 million annually. The variance will depend on future property values and the actual percentage of reimbursement. Anything less than the proposed 80% will increase the losses. Senior programs in Kent, Calhoun, and Midland counties will each lose over $100,000 per year, while Lenawee, Bay, St. Clair, St. Joseph, Saginaw, and Genesee counties will see losses of around $50,000 per year. Senior programs in Grand Traverse, Hillsdale, Berrien, Monroe, and Otsego counties will lose between $25,000 to $35,000 per year. Another fourteen counties with senior millages will lose $10-$20,000 per year, and the remainder smaller amounts. Not counted, but also due to have substantial impacts are city- based senior millages in the larger counties of Oakland and Macomb. Local communities use these dollars to both match and stretch state and federal senior funding, and local dollars also allow for innovation, infrastructure investment, and meeting unique community needs.

CONCLUSIONS

Michigan has demonstrated a considerable commitment to supporting the health and independence of its residents through expansion of its MI Choice Medicaid Waiver program, expansion of Medicaid health insurance, and continued commitment to the Department of Human Services' Medicaid Home Help program. However, support for disabled adults with limitations in their ability to perform necessary activity of daily living who are not eligible for Medicaid has been limited. Michigan has been plagued by chronic wait lists for many of the in-home services supported by state and federal Older Americans Act funding, such as home delivered meals, personal care, homemaking, respite, and chore services such as lawn care and snow removal. The network of area agencies on aging, county commissions and council on aging, disability network agencies, and other local direct service providers have invested considerable effort into addressing the wait list problem, including strategies such as:

- establishing or increasing senior millages;
- prioritizing and protecting in-home services when managing funding cuts;
- shifting funding from the congregate to the home delivered meals programs;
- increasing fundraising efforts; and
- increasing efficiency through a variety of programmatic and technological enhancements.

Despite these efforts, the Michigan Office of Services to the Aging's Aging Network has been unable to overcome the barriers of flat federal funding, recent reductions in state funding, and the growing demand associated with the aging of Michigan's population to resolve the wait list problem with existing resources. This creates a crisis for many of the thousands of near poor and middle class older adults whose independence is threatened by ADL limitations, and who do not qualify for Medicaid programs, but still cannot afford to purchase needed home care services at private market rates. These individuals and families are often forced to seek subsidized in-home services from Aging Network organizations, where they are placed to languish on wait lists for months or years.

This White Paper has documented the extent of unmet needs for in-home services supported through the Michigan Office of Services to the Aging, provided evidence of the hardship this situation imposes, assessed the costs and benefits of supporting the level of services needed by this population, and concluded that the Silver Key Coalition's goal of increasing funding for in-home services by $10 million over a three year period is a viable and needed strategy to address the present needs of those on wait lists for in-home services and eliminate wait lists as a persistent and structural problem in the future.

The key findings of this investigation that policy makers, legislators, advocates, and other stakeholders should know are:

- In 2014 there are nearly 4,500 seniors languishing on wait lists for basic services such as home-delivered meals and help with bathing, dressing, medication, shopping and household chores. About half of the individuals on the wait lists have been waiting for more than 180 days.

- Individuals on wait lists for extended periods of time are:
    - More likely to end up living in a nursing home
    - Less likely to remain living in their own home
    - More likely to seek health care from a hospital emergency room
    - More likely to die waiting for assistance.

- An increase of $5 million for the fiscal year 2015 will be needed to allow the Michigan Office of Services to the Aging in-home services programs to begin addressing the service needs of those on wait lists, accommodate anticipated new requests for assistance, and begin addressing the needs of the underserved population of individuals who are receiving assistance, but not in the amount that they need due to service rationing.

- The effort to make Michigan a "No Wait State" for in-home services will be a key component of a larger strategy to make Michigan a retirement destination of choice that attracts and retains retirees, and captures the significant social and economic benefits of an aging population.

- A $5 million investment will yield many collateral benefits to taxpayers, businesses and the state, including:
    - Creating approximately 200 new jobs
    - Leverage matching federal, local, and private contributions of an additional $1.7 million
    - Return approximately $350,000 in state tax revenue
    - 75% of food purchased from Michigan based sources.

A FY 2015 allocation of $5 million in state general revenue funding for in-home services provided through the Michigan Office of Services to the Aging, coupled with the leveraging of participant donations and other funding sources, will represent a significant first step in eliminating the state's chronic in-home service wait lists of older Michiganians.