GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Michigan, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/app/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Michigan, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in Michigan are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Michigan, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, Michigan's LTC system has been subject to three major policy reforms: the addition of a new coverage group of aged and disabled adults in 1995, changes to level of care criteria for nursing facility admission in 2004, and the implementation of a program to cover the new adult group under the Affordable Care Act in 2013.

Key Dates

First law: 1965

Major changes since 1992: 1995, 2004, 2013

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1994

Overview

Long-term care (LTC) benefits in Michigan are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Michigan is administered at the state level by the Michigan Department of Health and Human Services (MDHHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Michigan are mostly provided through state plan benefit programs (Home Help Program, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (MI Choice). The MI Choice program began only in select Michigan counties until 1998, when the program became available statewide.

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Help and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the MI Choice program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the MI Choice program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Home Help and Home Health require the individual to have a medical necessity for services, while Nursing Facility and MI Choice beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Michigan Law for Medicaid

- Social Welfare Act, 1939 PA 280, MCL 400 (Michigan Legislature, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Michigan Medicaid spending on beneficiaries in fiscal year 1992 was 55.41%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (55.41% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Michigan Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Michigan.

Eligibility for Medicaid in Michigan for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a Michigan resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[3]
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1992, this was $1,266 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in the MI Choice program.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. Exact income limits are pending requested documents.[8] Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Help Program, Home Health Services, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

MI Choice
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and physically disabled. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment.

Benefit

Home care benefit

Home Help Program
Home Help provides personal care services, which include (AARP, 1991; MDHHS, 2007b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration —see Table 3 for hour limitations on these services

Home Health Services
Home Health provides (42 CFR 440, 1996; MDHHS, 2018c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care
Nursing Facility Care does not provide home care during this policy period.

MI Choice
Unknown

Author's note: Information pending requested materials.[7] The Michigan Public Act 410 of 1988 that governed home and community-based program services during this time does not include a list of services as it does in subsequent years (Michigan Legislature, 1987).

Semi-residential care

Home Help Program, Home Health Services, Nursing Facility Care
These programs do not provide semi-residential care during this policy period.

MI Choice
Unknown

Author's note: Information pending requested materials.[7] The Michigan Public Act 410 of 1988 that governed home and community-based program services during this time does not include a list of services as it does in subsequent years (Michigan Legislature, 1987).

Residential care

Home Help Program, Home Health Services, MI Choice
These programs do not provide residential care during this policy period.

Nursing Facility Care
Medicaid provides care in two types of nursing facilities:

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board (MDHHS, 2010)
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment (NLM, 1988; MDHHS, 2004c; MDHHS, 2013b)

Other benefits

Michigan Medicaid provides additional benefits related to LTC:

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care (AARP, 1991)
- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services (MDHHS, 1992)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

MI Choice

Unknown

Author's Note: Information pending requested materials.[7] The Michigan Public Act 410 of 1988 that governed home and community-based program services during this time does not include a list of services as it does in subsequent years (Michigan Legislature, 1987).

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Michigan Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

The beneficiary must require some assistance with ADLs and/or housekeeping (ASPE, 1991b).

Home Health Services

The beneficiary must require skilled nursing services or physical therapy services in order to receive this benefit. Home health aide services will not be covered for individuals who do not also need nursing or physical therapy services (MSA, 1993a). Additionally, home health services will only be covered if one or more of the following conditions, circumstances, or situations exist (MSA, 1993b; MDCH, 2004):

- Leaving the home is medically unwise (not recommended because it may cause harm)
- Client is unable to leave the home except with the aid of supports (e.g., wheelchairs, walkers) or the use of special transportation —a client who is able to go to a physician for services but who does not have transportation will not be eligible unless the agency receives prior authorization from the Medical Services Administration (Michigan's agency responsible for administering Medicaid)
- Circumstances cause an unusual hardship for the client to obtain care at a physician's office or outpatient clinic
- The home health agency is the most appropriate provider of service

Nursing Facility Care

The beneficiary must meet an NFLOC determined by the Request for Prior Authorization of Medical Eligibility for Reimbursement for Skilled Nursing or Intermediate Care (R-19) form. While the R-19 form documents the applicant's current health status, status characteristics (e.g., diagnoses, illnesses) do not directly correspond to an objective level of care. Relevant department staff individually and subjectively review each form to determine level of care (MSA, 1992b). Generally, patients in an ICF will require health-related care and services but not to the degree of care and treatment which a hospital or SNF is designed to provide (MDHHS, 2010). SNFs provide a higher level of residential care to residents on a 24-hour basis whose primary need is skilled nursing services.

MI Choice

The beneficiary must meet an NFLOC in order to be admitted to the program, meaning that they would require admission to a nursing facility if not for the services provided under MI Choice (Michigan Legislature, 1987). However, Michigan has no objective criteria to determine nursing home eligibility or objective definition of dependence for this policy period.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (MDHHS, 2013).

Home Help Program

The needs assessment completed by the service worker must be approved by the beneficiary's physician within 60 days of the start of services. The authorization remains valid unless the physician specifies a time limit or chooses to review the assessment on an as-needed basis. A state registered nurse reviews all case documentation every 12 months (ASPE, 1991a).

Home Health Services

The beneficiary's physician must review the plan of care every 62 days (MSA, 1993b).

Nursing Facility Care

The facility must make a comprehensive assessment of a resident's needs within 14 days of admission, promptly after a change in condition, and at least once every 12 months. The assessments must be reviewed every 3 months (MSA, 1992a; 42 CFR 483, 1996). After admission, quarterly and annual Minimum Data Set (MDS) assessments and progress notes from nursing facility staff must demonstrate that the resident has met the criteria on an ongoing basis (MDCH, 2006; MDHHS, 2013b).

MI Choice

MI Choice participants must be reassessed at least every 12 months. However, it is possible that Michigan requires more frequent evaluations for this program.

Author's Note: Additional information pending requested materials.[7]

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Help Program, Home Health Services, Nursing Facility Care

There is no age requirement.

MI Choice

The individual must be at least age 65, or age 18-64 and physically disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Home Help services must be medically necessary as prescribed by a physician. This typically means that the applicant requires a need for some assistance with ADLs (ASPE, 1991c).

Author's Note: Additional information pending requested materials.[8]

Home Health Services

Home health is covered for beneficiaries whose conditions do not require continuous skilled nursing care, but do require skilled care on an intermittent basis in the home for the treatment of an injury, illness, or disability (42 CFR 440, 1996; MDCH, 2004).

Nursing Facility Care

Michigan has no objective criteria to determine nursing home eligibility during this policy period. Nursing facility staff document an individual's medical necessity for nursing home placement on an R-19 form, which is then reviewed by Michigan Department of Public Health staff who subjectively determine level of care (MSA, 1992b; Urban Institute, 1997; Fries, et. al., 2002). While the form requires the administrator to provide a justification for the level of care and plan of care recommended, items from the form do not directly correspond to objective levels of care.

MI Choice

Applicants for the MI Choice program must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of the MI Choice program (Michigan Legislature, 1987). However, Michigan has no objective criteria to determine nursing home eligibility or objective definition of dependence for this policy period.

Author's Note: Additional information on MI Choice eligibility is pending requested materials.[7]

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Federal law requires that state plan personal care services be authorized by a physician in accordance with the recipient's treatment plan (ASPE, 1991c). The local Department of Social Services conducts an assessment to determine eligibility and level of need for services. The assessment collects the following information (ASPE, 1991b):

- Physician's recommendation
- Functional abilities (ADLs)
- Accessibility of environment
- Whether the plan of care is less costly than institutionalization
- Services needed

However, each Michigan county has a different method for assessing the time allocated for different personal care tasks, creating the potential for a lack of uniformity in needs assessments (ASPE, 1991a).

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 440, 1996; MDCH, 2004):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

Nursing Facility Care

Michigan has no objective criteria to determine nursing home eligibility during this policy period. Nursing facility staff document an individual's medical necessity for nursing home placement using the Request for Prior Authorization of Medical Eligibility for Reimbursement for Skilled Nursing or Intermediate Care (R-19) form. To view the full form (in use since 1989), see MSA (1992b). Nurses at the state level then administratively review each R-19 form to determine level of care, typically after the person had already been institutionalized (MSA, 1992; Fries, et. al., 2002). Additional information on the sections of the R-19 form are detailed in Box 1.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

MI Choice

MI Choice applicants must be at risk of nursing home placement in order to be eligible for the program. However, Michigan has no objective criteria to determine nursing home eligibility.

Author's Note: Additional information regarding the MI Choice evaluation of dependence for this policy period is pending requested materials.[7]

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

An Adult Services Worker with the appropriate assessment training will evaluate the level of need for services through a county-specific assessment (ASPE, 1991a). The beneficiary's physician reviews the needs assessment at the start of services, and a state registered nurse will review the documentation annually.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (42 CFR 440, 1996; MDCH, 2004; MDHHS, 2018a).

Nursing Facility Care

R-19 forms are filled out by nursing facility staff, and Michigan Department of Public Health staff individually review these forms (MSA, 1992b).

MI Choice

Unknown

Author's Note: Information pending requested materials.[7]

Benefit limitations

Can you mix LTC benefits?

All Michigan Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

Michigan did not have an estate recovery program in operation until 2007.

Home Help Program, Home Health Services

Available Michigan state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1992, the PNA was $30 per month.

MI Choice

Unknown

Author's Note: Additional information pending requested materials.[7]

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 1995-2003

Policy change in 1995

In 1995, Michigan added a new eligibility track for aged, blind, or disabled adults to qualify for Medicaid, referred to here as Eligibility Track 2b (Federal Poverty Level Aged and Disabled). This track allowed all adults at least age 65, blind, or disabled to become eligible for Medicaid if their income was at or below 100% of the federal poverty level (FPL), and they met the asset limits for Supplemental Security Income (SSI) recipients (Urban Institute, 1997). Because this track is not tied to institutional status, it allows individuals who do not require nursing facility care but who still need some assistance more generous financial eligibility criteria than the other main eligibility track for this group, such as Eligibility Track 1a (SSI Recipients).

Other reforms during this period:

- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or SSI for at least five years after immigration, or until they attain citizenship (ASPE, 1996).
- (1997) Michigan made two significant changes related to LTC eligibility (UPCAP, 2018):
  - Adoption of the Minimum Data Set-Home Care (MDS-HC), a new assessment instrument for the MI Choice program
  - Implementation of a new LTC screening system that includes an initial telephone intake call to determine whether an applicant is likely to be eligible for MI Choice
- (1998) While in operation since 1992, the MI Choice program became available statewide in 1998 (Urban Institute, 2001).

Overview

Long-term care (LTC) benefits in Michigan are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Michigan is administered at the state level by the Michigan Department of Health and Human Services (MDHHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Michigan are mostly provided through state plan benefit programs (Home Help Program, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (MI Choice).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Help and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the MI Choice program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the MI Choice program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Home Help and Home Health require the individual to have a medical necessity for services, while Nursing Facility and MI Choice beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Michigan Law for Medicaid

- Social Welfare Act, 1939 PA 280, MCL 400 (Michigan Legislature, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Michigan Medicaid spending on beneficiaries in fiscal year 1995 was 56.84%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (56.84% in 1995), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Michigan Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Michigan.

Eligibility for Medicaid in Michigan for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1995, the monthly federal benefit amount was $458 for an individual and $687 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a Michigan resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1995, this was $1,374 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in the MI Choice program.
- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 1995, this was $623 for an individual and $836 for a household of two (ASPE, 2004). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income in order to meet a specific standard. This functions similar to a deductible. Exact income limits are pending requested documents.[8] Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Help Program, Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

MI Choice

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and physically disabled. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

Home Help Program

Home Help provides personal care services, which include (AARP, 1991; MDHHS, 2007b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration —see Table 3 for hour limitations on these services

Home Health Services

Home Health provides (42 CFR 440, 1996; MDHHS, 2018c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

MI Choice

MI Choice provides the following services in addition to those offered under the state plan, unless otherwise noted (Michigan Legislature, 1994; Urban Institute, 1997):

- Chore services, which may include (MDHHS, 2007a) —
  - Heavy household chores such as washing floors, windows and walls, and moving heavy items of furniture in order to provide safe access
  - Yard maintenance, such as moving, raking, and clearing debris
- Homemaker services: Performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance), provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and upkeep for him or herself or others in the home
- Personal care services: Services that differ slightly from the state plan Home Help service, as MI Choice personal care providers have more stringent qualification requirements and may provide skilled nursing services when appropriate
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent

Semi-residential care

Home Help Program, Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

MI Choice

MI Choice provides Adult Day Health Care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Michigan Legislature, 1994; Urban Institute, 2001; MDHHS, 2007a; Michigan Legislature, 2013; MDHHS, 2018d).

Residential care

Home Help Program, Home Health Services, MI Choice

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities:

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board (MDHHS, 2010)
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment (NLM, 1988; MDHHS, 2004c; MDHHS, 2013b)

Other benefits

Michigan Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services (MDHHS, 1992)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

MI Choice

MI Choice provides the following services in addition to those offered under the state plan, unless otherwise noted (Michigan Legislature, 1994; Urban Institute, 1997; Urban Institute, 2001; MDHHS, 2007a):

- Case Management (as described above under the state plan)
- Durable medical equipment and supplies: Referred to as specialized medical equipment and supplies under MI Choice, additional equipment and supplies that are necessary to address the participant's functional limitations
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-emergency transportation: Transportation to program services or other community services, activities, and resources
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant—services include:
  - Attendant care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation
  - Basic care (participant may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Michigan Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

The beneficiary must require some assistance with ADLs and/or housekeeping (ASPE, 1991b).

Home Health Services

The beneficiary must require skilled nursing services or physical therapy services in order to receive this benefit. Home health services will only be covered if one or more of the following conditions, circumstances, or situations exist (MSA, 1993b; MDCH, 2004):

- Leaving the home is medically unwise (not recommended because it may cause harm)
- Client is unable to leave the home except with the aid of supports (e.g., wheelchairs, walkers) or the use of special transportation —a client who is able to go to a physician for services but who does not have transportation will not be eligible unless the agency receives prior authorization from the Medical Services Administration (Michigan's agency responsible for administering Medicaid)
- Circumstances cause an unusual hardship for the client to obtain care at a physician's office or outpatient clinic
- The home health agency is the most appropriate provider of service

Nursing Facility Care

Individuals must meet an NFLOC and have a physician certify continuous need for nursing facility care. Patients in an ICF will require health-related care and services but not to the degree of care and treatment which a hospital or SNF is designed to provide (MDHHS, 2010). SNFs provide a higher level of residential care to residents on a 24-hour basis whose primary need is skilled nursing services.

MI Choice

The beneficiary must meet an NFLOC in order to be admitted to the program, meaning that they would require admission to a nursing facility if not for the services provided under MI Choice (Michigan Legislature, 1987). However, Michigan has no objective criteria to determine nursing home eligibility or objective definition of dependence for this policy period. Following the introduction of the new evaluation system in 1997, MI Choice still required an NFLOC, but it was defined by the applicant's need for intensive skilled nursing care, minimally skilled nursing care, and intensive personal care. These are defined further in the *Definition of Dependence* section for this policy period (chapter).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (MDHHS, 2013).

Home Help Program

The needs assessment completed by the service worker must be approved by the beneficiary's physician within 60 days of the start of services. The authorization remains valid unless the physician specifies a time limit or chooses to review the assessment on an as-needed basis. A state registered nurse reviews all case documentation every 12 months (ASPE, 1991a).

Home Health Services

The beneficiary's physician must review the plan of care every 60 days (42 CFR 440, 1996; MDCH, 2004).

Nursing Facility Care

The facility must make a comprehensive assessment of a resident's needs within 14 days of admission, promptly after a change in condition, and at least once every 12 months. The assessments must be reviewed every 3 months (MSA, 1992a; 42 CFR 483, 1996). After admission, quarterly and annual Minimum Data Set (MDS) assessments and progress notes from nursing facility staff must demonstrate that the resident has met the criteria on an ongoing basis (MDCH, 2006; MDHHS, 2013b).

MI Choice

Participants must be reassessed every 3 months (Urban Institute, 2001).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Help Program, Home Health Services, Nursing Facility Care

There is no age requirement.

MI Choice

The individual must be at least age 65, or age 18-64 and physically disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Home Help services must be medically necessary as prescribed by a physician. This typically means that the applicant requires a need for some assistance with ADLs (ASPE, 1991c).

Author's Note: Additional information pending requested materials.[8]

Home Health Services

Home health is covered for beneficiaries whose conditions do not require continuous skilled nursing care, but do require skilled care on an intermittent basis in the home for the treatment of an injury, illness, or disability (42 CFR 440, 1996; MDCH, 2004).

Nursing Facility Care

At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. The order specifies and certifies the need for care in a nursing facility (42 CFR 483, 1996).

MI Choice

Applicants for the MI Choice program must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of the MI Choice program (Michigan Legislature, 1987). However, Michigan has no objective criteria to determine nursing home eligibility or objective definition of dependence for this policy period.

Following the introduction of the new system in 1997, an NFLOC was still required to enroll in MI Choice (Michigan Legislature, 1994). It is now defined as the individual requiring one of the following (Fries, et. al., 2002):[11]

- Intensive skilled nursing care/therapy services (3+ times per week)
- Minimally skilled nursing care/therapy services (1 or 2 times per week)
- Intensive personal care services (daily assistance with multiple tasks)

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Federal law requires that state plan personal care services be authorized by a physician in accordance with the recipient's treatment plan (ASPE, 1991c). The local Department of Social Services conducts an assessment to determine eligibility and level of need for services. The assessment collects the following information (ASPE, 1991b):

- Physician's recommendation
- Functional abilities (ADLs)
- Accessibility of environment
- Whether the plan of care is less costly than institutionalization
- Services needed

However, each Michigan county has a different method for assessing the time allocated for different personal care tasks, creating the potential for a lack of uniformity in needs assessments (ASPE, 1991a).

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 440, 1996; MDCH, 2004):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

Nursing Facility Care

Individuals applying for nursing facility coverage have a physician's order for services and a determination of medical/functional eligibility based on the NFLOCD (MDCH, 2006; MDHHS, 2013b).

A physician's order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician, and the physician's degree must appear with the signature.

Individuals applying for institutional care must have a comprehensive assessment conducted prior to admission. See Box 4 for a list of items evaluated in the comprehensive assessment.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

MI Choice

Applicants must be at risk of nursing home placement in order to be eligible for the program. However, Michigan had no objective criteria to determine nursing home eligibility in 1995. The Office of Services to the Aging (OSA) developed a composite telephone screening process consisting of questions based in the literature on nursing home use and institutional risk. The number of criteria met was counted and compared with a subjectively determined threshold. The OSA screening has no empirical basis for either the independent contribution of the individual items or the selection of the threshold (Fries, et. al., 2002).

Beginning in 1997, MI Choice applicants followed a new screening and assessment process. First, individuals call a local MI Choice program agency and request services. During this call, the applicant would partake in a 15- to 20-minute screening to identify whether they are eligible for further assessment and possible program enrollment. Those deemed eligible for further assessment would then, at a later time, complete an in-person assessment (Minimum Data Set Home Care - MDS-HC) developed by the state (Fries, et. al., 2002).

Author's Note: Additional information on MI Choice evaluations and the MDS-HC is pending requested materials.[7]

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

An Adult Services Worker with the appropriate assessment training will evaluate the level of need for services through a county-specific assessment (ASPE, 1991a). The beneficiary's physician reviews the needs assessment at the start of services, and a state registered nurse will review the documentation annually.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (42 CFR 440, 1996; MDCH, 2004; MDHHS, 2018a).

Nursing Facility Care

A licensed physician must determine level of care and admission to a nursing facility (HHCSQ, 2001; 42 CFR 483, 1996).

MI Choice

Prior to 1997, an employee from the OSA would complete the eligibility screening.

Beginning in 1997, MI Choice applicants were first screened via telephone call by a local program employee, and later given an in-person assessment by a registered nurse and social worker (Fries, et. al., 2002).

Benefit limitations

Can you mix LTC benefits?

All Michigan Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

Michigan did not have an estate recovery program in operation until 2007.

Home Help Program, Home Health Services

Available Michigan state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1995, the PNA was $30 per month.

MI Choice

There are no copayments or similar charges imposed upon participants for program services.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2004-2012

Policy change in 2004

In 2004, Michigan implemented a new Nursing Facility Level of Care Determination (NFLOCD) instrument used in assessing eligibility for both institutional and community-based care settings. This affected nursing facility and MI Choice program admission (UPCAP, 2018). The Minimum Data Set - Home Care (MDS-HC) was maintained for developing the plan of care and used in quarterly evaluations.

Other reforms during this period:

- (2007) Michigan adopted the InterRAI Home Care Assessment System (iHC), an updated version of the MDS-HC, for a secondary evaluation of applicants for the MI Choice program. Once clinical (using the NFLOCD) and financial eligibility have been established, the iHC is completed by a program provider to collect information on the beneficiary's needs and to confirm that the program services (rather than state plan services) are most appropriate (CDSS, 2013). This replaced the previous MDS-HC.
- (2007) The Deficit Reduction Act of 2005 implemented a home equity limit of $500,000 for Medicaid applicants. Prior to this, in determining an applicant's assets, the value of an individual's home was usually exempt. Under the new law, a person with more than $500,000 in home equity is ineligible for nursing facility care under Medicaid. Homes occupied by a spouse or a disabled or minor child are exempt (Michigan Senate, 2006).
- (2007) Per federal law, Michigan implemented an estate recovery policy that allows the state to seek recovery from estates of certain deceased beneficiaries who received benefits from the Medicaid program. Estate recovery applies only to Medicaid beneficiaries who are at least age 55 that received long-term care (LTC) services any time on or after September 30, 2007, (Social Welfare Act Sec. 400.112g, 2007). Prior to this policy period, Michigan did not have an estate recovery program in operation.

Overview

Long-term care (LTC) benefits in Michigan are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Michigan is administered at the state level by the Michigan Department of Health and Human Services (MDHHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Michigan are mostly provided through state plan benefit programs (Home Help Program, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (MI Choice).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Help and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the MI Choice program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the MI Choice program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Home Help and Home Health require the individual to have a medical necessity for services, while Nursing Facility and MI Choice beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Michigan Law for Medicaid

- Social Welfare Act, 1939 PA 280, MCL 400 (Michigan Legislature, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Michigan Medicaid spending on beneficiaries in fiscal year 2004 was 55.89%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (55.89% in 2004), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Michigan Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Michigan.

Eligibility for Medicaid in Michigan for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2004, the monthly federal benefit amount was $564 for an individual and $846 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[12]
    - Home equity limit: Beginning in July 2007, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (Michigan Senate, 2006).[13]
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2004, this was $1,692 for an individual (MDHHS, 2004e). Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[14]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[15]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or enrolled in the MI Choice program.
- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 2004, this was $776 for an individual and $1,041 for a household of two (ASPE, 2004). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[14]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[15]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to a specific standard. This functions similar to a deductible. Exact income limits are pending requested documents.[8] Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[14]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[15]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Help Program, Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

MI Choice

Applicants must meet the following additional criteria beyond minimum level of dependence:

- At least age 65, or age 18-64 and physically disabled
- Require at least 1 program service on a monthly basis
- Ensure that needs cannot be fully met with state plan services (e.g., Home Help, Home Health) or other available services; applicants must require services that they can only obtain through MI Choice

If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

Home Help Program

Home Help provides personal care services, which include (AARP, 1991; MDHHS, 2007b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration —see Table 3 for hour limitations on these services

Home Health Services

Home Health provides (42 CFR 440, 1996; MDHHS, 2018c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

MI Choice

MI Choice provides the following services in addition to those offered under the state plan, unless otherwise noted (Michigan Legislature, 1994; Urban Institute, 1997):

- Chore services, which may include (MDHHS, 2007a) —
  - Heavy household chores such as washing floors, windows and walls, and moving heavy items of furniture in order to provide safe access
  - Yard maintenance, such as moving, raking, and clearing debris
- Homemaker services: Performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance), provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and upkeep for him or herself or others in the home
- Personal care services: Services that differ slightly from the state plan Home Help service, as MI Choice personal care providers have more stringent qualification requirements and may provide skilled nursing services when appropriate
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent

Semi-residential care

Home Help Program, Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

MI Choice

MI Choice provides Adult Day Health Care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Michigan Legislature, 1994; Urban Institute, 2001; MDHHS, 2007a; Michigan Legislature, 2013; MDHHS, 2018d).

Residential care

Home Help Program, Home Health Services, MI Choice

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities:

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board (MDHHS, 2010)

- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment (NLM, 1988; MDHHS, 2004c; MDHHS, 2013b)

Other benefits

Michigan Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services (MDHHS, 1992)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

MI Choice

MI Choice provides the following services in addition to those offered under the state plan, unless otherwise noted (Michigan Legislature, 1994; Urban Institute, 1997; Urban Institute, 2001; MDHHS, 2007a):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Referred to as specialized medical equipment and supplies under MI Choice, additional equipment and supplies that are necessary to address the participant's functional limitations
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-emergency transportation: Transportation to program services or other community services, activities, and resources
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant [16] —
  - Attendant care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation
  - Basic care (participant may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Michigan Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

The beneficiary must require assistance with at least one ADL at a dependence of Level 3 or higher (MDHHS, 2004b). Dependence is determined by the beneficiary establishing an ADL need. ADL needs may be established in several ways. See *Definition of Dependence* and *Evaluation of Dependence* for more information on establishing an ADL need and other requirements.

Home Health Services

The beneficiary must require skilled nursing services or physical therapy services in order to receive this benefit. Home health services will only be covered if one or more of the following conditions, circumstances, or situations exist (MSA, 1993b; MDCH, 2004):

- Leaving the home is medically unwise (not recommended because it may cause harm)

- Client is unable to leave the home except with the aid of supports (e.g., wheelchairs, walkers) or the use of special transportation —a client who is able to go to a physician for services but who does not have transportation will not be eligible unless the agency receives prior authorization from the Medical Services Administration (Michigan's agency responsible for administering Medicaid)
- Circumstances cause an unusual hardship for the client to obtain care at a physician's office or outpatient clinic
- The home health agency is the most appropriate provider of service

Nursing Facility Care

Individuals must meet an NFLOC and have a physician certify continuous need for nursing facility care. Patients in an ICF will require health-related care and services but not to the degree of care and treatment which a hospital or SNF is designed to provide (MDHHS, 2010). SNFs provide a higher level of residential care to residents on a 24-hour basis whose primary need is skilled nursing services.

MI Choice

The beneficiary must meet an NFLOC in order to be admitted to the program, meaning that they would require admission to a nursing facility if not for the services provided under MI Choice. This is defined further in the *Definition of Dependence* and *Evaluation of Dependence* sections for this policy period (chapter).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (MDHHS, 2013).

Home Help Program

Cases must be reviewed every 6 months. They will include a review of the completed assessment and plan of care and verify the beneficiary's Medicaid eligibility. Continued medical eligibility is determined by the Medical Needs form (FIA-54A), and must be completed every 12 months (MDHHS, 2004b; MDHHS, 2015).

Home Health Services

The beneficiary's physician must review the plan of care every 60 days (42 CFR 440, 1996; MDCH, 2004).

Nursing Facility Care

The NFLOCD is used to assess a nursing facility applicant only once prior to admission. After admission, quarterly and annual Minimum Data Set (MDS) assessments and progress notes from nursing facility staff must demonstrate that the resident has met the criteria on an ongoing basis (MDCH, 2006; MDHHS, 2013b).

MI Choice

Reassessments using the NFLOCD may occur annually but are not required. MDS-HC assessments are required every 3 months to update the plan of care. From 2007, iHC reassessments occur every 3 months for patients classified as active status and 6 months for maintenance status (MDHHS, 2007a; MDHHS, 2013).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Help Program, Home Health Services, Nursing Facility Care

There is no age requirement.

MI Choice

The individual must be at least age 65, or age 18-64 and physically disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Individuals must require assistance with at least one ADL at Level 3 or higher. Level 3 is defined as "the applicant performs the activity with some direct physical assistance and/or assistive technology."

Author's Note: Definitions of other ADL levels for this policy period chapter are pending requested materials.[7] For definitions as of 2018, see Box 7 and MDHHS (2018b).

Home Health Services

Home health is covered for beneficiaries whose conditions do not require continuous skilled nursing care, but do require skilled care on an intermittent basis in the home for the treatment of an injury, illness, or disability (42 CFR 440, 1996; MDCH, 2004).

Nursing Facility Care

Applicants must meet an NFLOC in order to be admitted to a nursing facility. An NFLOC is met if the applicant satisfies all criteria for at least one of the seven "doors" on the NFLOCD. See Box 8 for definitions on each of the doors.

MI Choice

During the telephone intake, if the applicant responds "Yes" to any of the questions asked, they will qualify for an in-person assessment.

Applicants for the MI Choice program must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of the MI Choice program (Michigan Legislature, 1994; Michigan Legislature, 2013). This is determined by the in-person assessment, which follows the same level of care process and corresponding definitions as detailed above for nursing facility care (using the NFLOCD). However, meeting the minimum level of dependence for MI Choice does not guarantee admission to the program. Program space is limited to a specific number of beneficiaries. When the number of program participants exceeds program capacity, individuals are placed on a prioritized wait list. When a spot opens up, individuals are released from the wait list in order of priority. See Box 9 for the wait list priority order.

Additionally, after an applicant has been deemed eligible using the NFLOCD, they also must be assessed using the iHC. The iHC assesses the applicant's initial and ongoing need for services and is used to develop the plan of care. At the time of the second reassessment, the iHC also places the applicant into either active status or maintenance status, which determines their reassessment timeline (MDHHS, 2013b).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Home Help services are only available to beneficiaries who are identified as medically and/or physically disabled, or cognitively impaired by a Medicaid enrolled physician, occupational therapist, physical therapist and/or nurse practitioner. Applicants must require assistance with at least 1 ADL. The need for assistance must be assessed as Level 3 or higher, based on the beneficiary's ability to perform each ADL that is then correlated to a five-point scale. An ADL need may be established in any of the following ways (MDHHS, 2004b):

- Have an ADL functional need authorized by a FIA Adult Services Worker
- Have a functional need for an ADL performed by relatives or friends with no reimbursement required
- Require equipment or assistive technology to accomplish an ADL; requirement must be documented by an FIA Adult Services Worker
- Authorized exception by the Department of Community Health, Long Term Care Systems Development Section

Additionally, continued eligibility is determined by the Medical Needs form (FIA 54A), which certifies the continued need for services. The FIA-54A is a not an evaluation, but a certification from a physician, physician assistant, nurse practitioner, occupational or physical therapist that the applicant requires personal care services. To view the form, see MDHHS (2015).

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 440, 1996; MDCH, 2004):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

Nursing Facility Care

Individuals applying for nursing facility coverage have a physician's order for services and a determination of medical/functional eligibility based on the NFLOCD (MDCH, 2006; MDHHS, 2013b).

A physician's order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician, and the physician's degree must appear with the signature.

Individuals applying for institutional care must be evaluated using the Michigan Medicaid NFLOCD. To view the full assessment form, see MDHHS (2004a). The assessment consists of seven medical/functional domains, called "doors." Applicants need only to qualify through one door in order to meet an NFLOC. The definitions of eligibility for each door are defined in the *Definition of Dependence* section of this policy period. See Box 5 for a detailed list of each door and its corresponding response options (UCSF, 2015; MDHHS, 2018d).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

MI Choice

Individuals must first complete a telephone intake when requesting services through the program. The telephone intake is a list of questions that identify potential MI Choice participants for further assessment and does not determine eligibility. The intake consists of 1-2 questions for each door outlined above from the NFLOCD that will determine whether an applicant has the potential to qualify for the program after an in-person assessment. See Box 6 for details on the screening.

If deemed eligible for further assessment, individuals applying for the program use the same form as outlined above for Nursing Facility Care (NFLOCD). Following the NFLOC determination, the Minimum Data Set Home Care (MDS-HC) assessment is used to develop the plan of care. From 2007, the InterRAI Home Care (iHC) assessment tool was introduced as a secondary evaluation that assisted in developing the beneficiary's plan of care after NFLOC eligibility had been determined. This replaced the previous MDS-HC used to develop a plan of care. Generally, both the MDS-HC and iHC assess the same domains as the MDS, detailed above for nursing facility care.

Author's Note: Additional information on the MDS-HC and iHC is pending requested materials.[7]

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

A Family Independence Agency (FIA) Adult Services Worker with the appropriate assessment training will evaluate the level of need for services. A Medicaid-enrolled physician, nurse practitioner, physical or occupational therapist must fill out the FIA-54A.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (42 CFR 440, 1996; MDCH, 2004; MDHHS, 2018a).

Nursing Facility Care

A licensed physician must determine level of care and admission to a nursing facility (HHCSQ, 2001). The NFLOCD must be completed by a physician, registered nurse, licensed practical nurse, licensed social worker, or a physician assistant.

MI Choice

MI Choice uses the same evaluator criteria for the NFLOCD as detailed above for nursing facility care (MDHHS, 2007a). Reassessments are conducted by supports coordinators. It is required that either a licensed social worker or a registered nurse be present (generally whichever professional is more appropriate to addressing the individual circumstances faced by the participant).

Benefit limitations

Can you mix LTC benefits?

All Michigan Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

In 2007, Michigan implemented a Medicaid Estate Recovery program as required by federal law. Medicaid recovery allows the Medicaid agency to file a claim against the estate of a Medicaid recipient after their death. Estate recovery applies to those Medicaid recipients who have received services at any time on or after September 30, 2007, and who were 55 years of age or older at the time of provision of the service (Social Welfare Act Sec. 400.112g, 2007).

Home Help Program, Home Health Services

Available Michigan state documents do not detail policy on copayments or related charges, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2004, the PNA was $60 per month (MDHHS, 2004d).

MI Choice

There are no copayments or similar charges imposed upon participants for program services.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 4: Policy enacted 2013-2023

Policy change in 2013

In 2013, Michigan received approval to implement an eligibility track covering the new adult group under the Affordable Care Act (ACA). The track covers individuals aged 19-64 with incomes up to 138% of the federal poverty level (FPL) who are ineligible for Medicaid under any existing categorical groups. Michigan previously covered this group only through a rigid program that did not include long-term care (LTC) benefits. The eligibility track, referred to here as Eligibility Track 2c (ACA expansion adults), was approved as an alternative program called the Healthy Michigan Plan (HMP) rather than through a state plan amendment. However, beneficiaries under the HMP may receive the same state plan benefit package.

The ACA also required states to extend spousal impoverishment rules to individuals receiving LTC through home and community-based services (HCBS) programs, including MI Choice. From 2014, additional income and asset disregards applied to the community spouse of an individual receiving HCBS through Medicaid.

Additionally, Michigan implemented key changes to the MI Choice program in 2013. These policy changes include (MDHHS, 2014a):

- Shifting benefits to a managed care delivery system
- Requiring a medical reassessment after the first 90 days in the program, followed by reassessments every 3 months thereafter
- Requiring that an enrollee need at least 2 program services with one being case management
- Adding intermittent skilled nursing services and caregiver training to the available benefits
- Transferring personal care and homemaker services to the existing community living supports benefit
- Renaming the nursing facility transition benefit to community transition services

Other reforms during this period:

- (2018) MI Choice service plan reassessment frequency changed to 90 days after the initial assessment then annually thereafter (MDHHS, 2018d).
- (2018) State plan fee-for-service (FFS) Home health services implemented a requirement for prior authorization for all beneficiaries after the initial 90 days of services, and every 90 days thereafter for continuation of services (MDHHS, 2018c).

Overview

Long-term care (LTC) benefits in Michigan are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Michigan is administered at the state level by the Michigan Department of Health and Human Services (MDHHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Michigan are mostly provided through state plan benefit programs (Home Help Program, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (MI Choice).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Help and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the MI Choice program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the MI Choice program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Home Help and Home Health require the individual to have a medical necessity for services, while Nursing Facility and MI Choice beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Michigan Law for Medicaid

- Social Welfare Act, 1939 PA 280, MCL 400 (Michigan Legislature, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Michigan Medicaid spending on beneficiaries in fiscal year 2013 was 66.39%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (66.39% in 2013), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Michigan Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Michigan.

Eligibility for Medicaid in Michigan for people needing LTC services is primarily attained by satisfying at least one of 5 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2013, the monthly federal benefit amount was $710 for an individual and $1,066 for a couple (SSA, 2013). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[17]
    - Home equity limit: The equity interest in the individual's home may not exceed $536,000, or else they will be ineligible for LTC services (LTC Commission, 2013). This figure increases annually with inflation (Michigan Senate, 2006).[13]
  - Citizenship/immigration requirements: The applicant must be a Michigan resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2013, this was $2,130 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[18]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[19]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in the MI Choice program.
- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 2013, this was $958 for an individual and $1,293 for a household of two (ASPE, 2013). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[18]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[19]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]
- 2c. Affordable Care Act (ACA) expansion adults

  In Michigan, this eligibility track is called the Healthy Michigan Plan, and has slight differences from other states.[20]
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2013, this was $1,274 for an individual and $1,719 for a household of two. See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - Applicants must be ages 19-64, ineligible for Medicare, ineligible for other Medicaid eligibility tracks, and not pregnant at the time of application.[21]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to meet a specific standard. This functions similar to a deductible. The spend down amount is calculated on a monthly basis and is determined by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income. The resulting amount must be spent on qualifying medical bills and services in order to receive Medicaid coverage for the remainder of the month. PILs vary by family size and geographic area. In 2013, the PIL for an individual ranged from $341 to $408. For a household of 2, the PIL ranged from $458 to $541 (MDHHS, 2013a). Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[18]
  - Asset requirements: Same asset requirements as eligibility track 2a. Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[19]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Help Program, Home Health Services, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

MI Choice
Applicants must meet the following additional criteria beyond minimum level of dependence:

- At least age 65, or age 18-64 and physically disabled
- Require at least 2 program services on a monthly basis, with one being case management
- Ensure that needs cannot be fully met with state plan services (e.g., Home Help, Home Health) or other available services; applicants must require services that they can only obtain through MI Choice

If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- MI Health Link (from 2014)
- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

Home Help Program
Home Help provides personal care services, which include (AARP, 1991; MDHHS, 2007b):

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration —see Table 3 for hour limitations on these services

Home Health Services
Home Health provides (42 CFR 440, 1996; MDHHS, 2018c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care
Nursing Facility Care does not provide home care during this policy period.

MI Choice
MI Choice provides the following services in addition to those offered under the state plan, unless otherwise noted (Michigan Legislature, 2013):

- Chore services, which may include (MDHHS, 2018d) —
  - Heavy household chores such as washing floors, windows and walls, and moving heavy items of furniture in order to provide safe access
  - Yard maintenance, such as moving, raking, and clearing debris
- Community living supports: Personal care services, homemaker services, and additional services such as dementia care, transportation, and social participation (MDHHS, 2019)
- Private duty nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent) and respiratory care for participants who are ventilator dependent
- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse (limited to two hours per visit)

Semi-residential care

Home Help Program, Home Health Services, Nursing Facility Care
These programs do not provide semi-residential care during this policy period.

MI Choice

MI Choice provides Adult Day Health Care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Michigan Legislature, 1994; Urban Institute, 2001; MDHHS, 2007a; Michigan Legislature, 2013; MDHHS, 2018d).

Residential care

Home Help Program, Home Health Services, MI Choice

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities:

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board (MDHHS, 2010)
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment (NLM, 1988; MDHHS, 2004c; MDHHS, 2013b)

Other benefits

Michigan Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services (MDHHS, 1992)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

MI Choice

MI Choice provides the following services in addition to those offered under the state plan, unless otherwise noted (MDHHS, 2007a; Michigan Legislature, 2013):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care (renamed "Supports Coordination")
- Durable medical equipment and supplies: Referred to as specialized medical equipment and supplies under MI Choice, additional equipment and supplies that are necessary to address the participant's functional limitations
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-emergency transportation: Transportation to program services or other community services, activities, and resources
- Personal emergency response systems (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant [16] —
  - Attendant care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation
  - Basic care (participant may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication
- Training: Instruction provided to a waiver participant or caregiver in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically related procedures required to maintain the participant in a home or community-based setting
- Community transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Michigan Department of Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

The beneficiary must require assistance with at least one ADL at a dependence of Level 3 or higher (MDHHS, 2004b). Dependence is determined by the beneficiary establishing an ADL need using the functional component of the Adult Services Comprehensive Assessment (MDHHS-5534). See *Definition of Dependence* and *Evaluation of Dependence* for more information on establishing an ADL need and other requirements.

Home Health Services

The beneficiary must require skilled nursing services or physical therapy services in order to receive this benefit. After 2018, this requirement was removed, and beneficiaries could receive only home health aide services if ordered by a physician (MDHHS, 2018a).

Nursing Facility Care

Individuals must meet an NFLOC and have a physician certify continuous need for nursing facility care. Patients in an ICF will require health-related care and services but not to the degree of care and treatment which a hospital or SNF is designed to provide (MDHHS, 2010). SNFs provide a higher level of residential care to residents on a 24-hour basis whose primary need is skilled nursing services.

MI Choice

The beneficiary must meet an NFLOC in order to be admitted to the program, meaning that they would require admission to a nursing facility if not for the services provided under MI Choice. This is defined further in the *Definition of Dependence* and *Evaluation of Dependence* sections for this policy period (chapter).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (MDHHS, 2013).

Home Help Program

Cases must be reviewed every 6 months. They will include a review of the completed assessment and plan of care and verify the beneficiary's Medicaid eligibility. Continued medical eligibility is determined by the Medical Needs form (FIA-54A), and must be completed every 12 months (MDHHS, 2004b; MDHHS, 2015).

Home Health Services

The beneficiary's plan of care must be reviewed by the physician that ordered the services at least every 60 days, except for medical supplies and equipment, which may be reviewed on an annual basis (MDHHS, 2013b); (MDHHS, 2018c). For beneficiaries receiving FFS home health aide services, prior authorization is required if services exceed a period of three months. Continued need beyond each 3-month period requires a new authorization form to be submitted. For beneficiaries enrolled in a Medicaid health plan (managed care), the provider must check with the health plan for prior authorization requirements.

Nursing Facility Care

The NFLOCD is used to assess a nursing facility applicant only once prior to admission. After admission, quarterly and annual Minimum Data Set (MDS) assessments and progress notes from nursing facility staff must demonstrate that the resident has met the criteria on an ongoing basis (MDCH, 2006; MDHHS, 2013b).

MI Choice

Reassessments using the NFLOCD may occur annually but are not required. iHC reassessments occur every 3 months for patients classified as active status and 6 months for maintenance status (MDHHS, 2007a; MDHHS, 2013). In 2018, the requirement changed

to a reassessment after 3 months of services, followed by reassessments every 12 months thereafter, unless there is a significant change in condition that may affect their current eligibility status (MDHHS, 2018d).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Help Program, Home Health Services, Nursing Facility Care

There is no age requirement.

MI Choice

The individual must be at least age 65, or age 18-64 and physically disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Individuals must require assistance with at least one ADL at Level 3 or higher. Level 3 is defined as "the applicant performs the activity with some direct physical assistance and/or assistive technology" (MDHHS, 2021). The full 5-point scale is detailed in Box 7. For more detailed point scales for each assessed ADL, see MDHHS (2018b).

Home Health Services

Home health is covered for beneficiaries whose conditions do not require continuous skilled nursing care, but do require skilled care on an intermittent basis in the home for the treatment of an injury, illness, or disability (42 CFR 440, 1996; MDCH, 2004). Additional information on the definitions of dependence for this period are detailed in Box 11. After 2018, beneficiaries can receive only home health aide services (no skilled care required) if a physician orders and certifies the need for these services (MDHHS, 2018a).

Nursing Facility Care

Applicants must meet an NFLOC in order to be admitted to a nursing facility. An NFLOC is met if the applicant satisfies all criteria for at least one of the seven "doors" on the NFLOCD. See Box 8 for definitions on each of the doors.

MI Choice

During the telephone intake, if the applicant responds "Yes" to any of the questions asked, they will qualify for an in-person assessment.

Applicants for the MI Choice program must meet an NFLOC, meaning that they would require admission to a nursing facility if not for the existence of the MI Choice program (Michigan Legislature, 1994; Michigan Legislature, 2013). This is determined by the in-person assessment, which follows the same level of care process and corresponding definitions as detailed above for nursing facility care (using the NFLOCD). However, meeting the minimum level of dependence for MI Choice does not guarantee admission to the program. Program space is limited to a specific number of beneficiaries. When the number of program participants exceeds program capacity, individuals are placed on a prioritized wait list. When a spot opens up, individuals are released from the wait list in order of priority. See Box 9 for the wait list priority order.

Additionally, after an applicant has been deemed eligible using the NFLOCD, they also must be assessed using the iHC. The iHC assesses the applicant's initial and ongoing need for services and is used to develop the plan of care. At the time of the second reassessment, the iHC also places the applicant into either active status or maintenance status, which determines their reassessment timeline (MDHHS, 2013b).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

Upon requesting personal care services, a caseworker will provide a form for the applicant's medical professional to complete, the Medical Needs form (DHS-54A), which certifies their need for services. The DHS-54A is a not an evaluation, but a certification from a physician, physician assistant, nurse practitioner, occupational or physical therapist that the applicant requires personal care services. To view the form, see MDHHS (2015).

After the department receives the signed and completed form DHS-54A, the caseworker will make an appointment for a face-to-face assessment that determines necessity and level of care required using the Adult Services Comprehensive Assessment (MDHHS-5534). There are two components to the MDHHS-5534: the medical component, and functional component. The medical component uses the DHS-54A to input information regarding the physician(s), diagnosis, other health issues, adaptive equipment, medical treatments, and medications. The functional component is the basis for service planning and for the personal care services payment. Individuals are assessed for each ADL and IADL using the 5-point scale detailed in Box 7 (MDHHS, 2021). For more detailed point scales for each assessed ADL, see MDHHS (2018b).

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 440, 1996; MDCH, 2004):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care
- Documentation regarding the medical necessity for the service(s) to be provided at home
- Home health services needed
- Frequency and duration of the needed services
- Minimum skill level (nurse, home health aide) of staff who can provide the services

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

Nursing Facility Care

Individuals applying for nursing facility coverage have a physician's order for services and a determination of medical/functional eligibility based on the NFLOCD (MDCH, 2006; MDHHS, 2013b).

A physician's order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician, and the physician's degree must appear with the signature.

Individuals applying for institutional care must be evaluated using the Michigan Medicaid NFLOCD. To view the full assessment form, see MDHHS (2004a). The assessment consists of seven medical/functional domains, called "doors." Applicants need only to qualify through one door in order to meet an NFLOC. The definitions of eligibility for each door are defined in the *Definition of Dependence* section of this policy period. See Box 9 for a detailed list of each door and its corresponding response options (UCSF, 2015; MDHHS, 2018d).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

MI Choice

Individuals must first complete a telephone intake when requesting services through the program. The telephone intake asks applicants about everyday tasks to learn more about their current health status and determine whether they may be eligible for the program and what their priority level on the program waiting list will be. See Box 10 for details on the screening. To view the full intake, see MDHHS (2014b).

If deemed eligible for further assessment, individuals applying for the program use the same form as outlined above for Nursing Facility Care (NFLOCD). The InterRAI Home Care (iHC) assessment tool is used as a secondary evaluation that assists in developing the beneficiary's plan of care after NFLOC eligibility had been determined. Generally, the iHC assesses the same domains as the MDS, detailed above for nursing facility care.

Author's Note: Additional information on the iHC is pending requested materials.[7]

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Help Program

A Family Independence Agency (FIA) Adult Services Worker with the appropriate assessment training will evaluate the level of need for services through the MDHHS-5534. A Medicaid-enrolled physician, nurse practitioner, physical or occupational therapist must fill out the DHS-54A.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (42 CFR 440, 1996; MDCH, 2004; MDHHS, 2018a).

Nursing Facility Care

A licensed physician must determine level of care and admission to a nursing facility (HHCSQ, 2001). The NFLOCD must be completed by a physician, registered nurse, licensed practical nurse, licensed social worker, or a physician assistant.

MI Choice

MI Choice uses the same evaluator criteria for the NFLOCD as detailed above for nursing facility care (MDHHS, 2007a). Initial iHC assessments are conducted by a team consisting of a minimum of a registered nurse and a social worker. Reassessments using the iHC are conducted by either a properly licensed registered nurse or a social worker, whichever is most appropriate to address the circumstances of the participant (MDHHS, 2013b).

Benefit limitations

Can you mix LTC benefits?

All Michigan Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Michigan enforces Estate Recovery. The acceptance of Medicaid in Michigan creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Social Welfare Act Sec. 400.112g, 2007).

Home Help Program, Home Health Services

Beneficiaries entitled to Medicaid and Medicare (i.e., dually eligible) are exempt from copayments.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2013, the PNA was $60 per month.

MI Choice

There are no copayments or similar charges imposed upon participants for program services (Medicaid.gov, 2019).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Michigan Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	55.41%
1993	55.84
1994	56.37
1995	56.84
1996	56.77
1997	55.20
1998	53.58
1999	52.72
2000	55.11
2001	56.18
2002	56.36
2003	57.37
2004	58.10
2005	56.71
2006	56.59
2007	56.38
2008	58.10
2009	70.13
2010	73.27
2011	70.59
2012	66.14
2013	66.39
2014	66.32
2015	65.54
2016	65.60
2017	65.15
2018	64.78
2019	64.45
2020	68.71
2021	70.28
2022	71.68
2023[1]	69.69

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201). [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical Michigan Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422.00	$633.00	$1,266.00	$1899.00	$568.00	$766.00		
1993	434.00	652.00	1,302.00	1,956.00	581.00	786.00		
1994	446.00	669.00	1,338.00	2,007.00	614.00	820.00		
1995	458.00	687.00	1,374.00	2,061.00	623.00	836.00		
1996	470.00	705.00	1,410.00	2,115.00	645.00	864.00		
1997	484.00	726.00	1,452.00	2,178.00	658.00	885.00		
1998	494.00	741.00	1,482.00	2,223.00	671.00	905.00		
1999	500.00	751.00	1,500.00	2,253.00	687.00	922.00		
2000	513.00	769.00	1,539.00	2,307.00	696.00	938.00		
2001	531.00	796.00	1,593.00	2,388.00	716.00	968.00		
2002	545.00	817.00	1,635.00	2,451.00	739.00	995.00		
2003	552.00	829.00	1,656.00	2,487.00	749.00	1,010.00		
2004	564.00	846.00	1,692.00	2,538.00	776.00	1,041.00		
2005	579.00	869.00	1,737.00	2,607.00	798.00	1,070.00		
2006	603.00	904.00	1,809.00	2,712.00	817.00	1,100.00		
2007	623.00	934.00	1,869.00	2,802.00	851.00	1,141.00		
2008	637.00	956.00	1,911.00	2,868.00	867.00	1,167.00		
2009	674.00	1,011.00	2,022.00	3,033.00	903.00	1,215.00		
2010	674.00	1,011.00	2,022.00	3,033.00	903.00	1,215.00		
2011	674.00	1,011.00	2,022.00	3,033.00	908.00	1,226.00		
2012	698.00	1,048.00	2,094.00	3,144.00	931.00	1,261.00		
2013	710.00	1,066.00	2,130.00	3,198.00	958.00	1,293.00	1,274.00	1,719.00
2014	721.00	1,082.00	2,163.00	3,246.00	973.00	1,311.00	1,343.00	1,809.00
2015	733.00	1,100.00	2,199.00	3,300.00	981.00	1,328.00	1,354.00	1,832.00
2016	733.00	1,100.00	2,199.00	3,300.00	990.00	1,335.00	1,367.00	1,843.00
2017	735.00	1,103.00	2,205.00	3,309.00	1,005.00	1,354.00	1,387.00	1,868.00
2018	750.00	1,125.00	2,250.00	3,375.00	1,012.00	1,372.00	1,397.00	1,893.00
2019	771.00	1,157.00	2,313.00	3,471.00	1,041.00	1,410.00	1,437.00	1,945.00
2020	783.00	1,175.00	2,349.00	3,525.00	1,064.00	1,437.00	1,468.00	1,983.00
2021	794.00	1,191.00	2,382.00	3,573.00	1,074.00	1,452.00	1,482.00	2,004.00
2022	841.00	1,261.00	2,523.00	3,783.00	1,133.00	1,526.00	1,564.00	2,106.00
2023	914.00	1,371.00	2,742.00	4,113.00	1,215.00	1,643.00	1,677.00	2,268.00

Source: SSA (2023a) **Notes:** Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2013, corresponding to the implementation of the new eligibility track under the Affordable Care Act.

Table 3: Hour Limits Per Calendar Month for Home Help Personal Care Services

Service	Hour Limit
Shopping	5 hours
Light housekeeping	6 hours
Laundry	7 hours
Meal preparation	25 hours

Source: MDHHS (2007b)

Box 1: Nursing Facility Care R-19 Form (1992-1994)

The R-19 form contains the following sections and available responses:

- Current medications: List method and frequency of actual administration
- Diet: Regular, diabetic, other
- Teeth: Own, dentures, edentulous
- Skin: Normal, Decubiti stage (I, II, III, IV), other
- Sensory and communication (vision, hearing and speech): Normal, impaired, absent; whether the applicant has glasses and/or a hearing aid
- Mental state: Oriented, confused, belligerent, withdrawn, overactive, noisy, other
- Ability to perform ADLs: Independent, needs appliance, completely dependent
- Previous living arrangement: Alone, household help, spouse, other relative, non-relative
- Client is able to ("yes" or "no"): Live alone, climb stairs, clean house, prepare meals, communicate
- Incontinence (bowels and bladder): None, partial, complete; whether the applicant has ileostomy/colostomy, irrigations, indwelling tubes (catheter, tracheotomy, other); whether dressing are simple, complex, wet, dry, or other

Source: MSA (1992)

Box 2: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 3: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Box 4: Nursing Facility Care Comprehensive Assessment Items (1995-2003)

The comprehensive assessment contains the following:

- Medically defined conditions and prior medical history
- Physical and mental functional status
- Sensory and physical impairments
- Nutritional status and requirements
- Special treatments or procedures
- Mental and psychosocial status
- Discharge potential
- Dental condition
- Activities potential
- Rehabilitation potential
- Cognitive status
- Drug therapy

Source: 42 CFR 483 (1996)

Box 5: Nursing Facility Level of Care Determination (NFLOCD) Form Items (2004-2023)

The assessment includes the following sections and possible response options:

1. ADL Dependency: Self-ability in (a) Bed (sleeping surface) mobility, (b) transfers, (c) toilet use, and (d) eating in the last 7 days
    - Independent or supervision = 1
    - Limited assistance = 3 (for eating, this corresponds to 2 points)
    - Extensive assistance or total dependence = 4 (for eating, this corresponds to 3 points)
    - Activity did not occur during the entire 7-day period regardless of ability (applicant was not mobile, did not transfer, did not toilet, did not eat) = 8
2. Cognitive Performance: The Cognitive Performance Scale (detailed in the form) is used to identify cognitive difficulties with short-term memory and daily decision-making.
    - Short-term memory: Determine the applicant's functional capacity to remember recent events.
    - Cognitive skills for daily decision-making: Review events of the last 7 calendar days and score how the applicant made decisions regarding tasks of daily life.
    - Making self understood: Within the last 7 days, document the applicant's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation.
3. Physician Involvement: The number of days in which the physician or authorized assistant/practitioner examined the applicant or changed orders in the last 14 calendar days.
4. Treatments and Conditions: Document treatments/conditions out of the specified list that were evidenced within the last 14 days (e.g., stage 3-4 pressure sores, intravenous medications, pneumonia).
5. Skilled Rehabilitation Therapies: Skilled rehabilitation interventions is based on ordered AND scheduled therapy services within the last 7 calendar days. Record the total minutes speech, occupational, and physical therapy was administered for at least 15 minutes a day, and the estimated total number of each therapy minutes the applicant was scheduled for, but did not receive.
6. Behavior: Document whether the applicant has displayed any behaviors that are specified on the form (e.g., wandering, hallucinations) in the last 7 days.
7. Service Dependency: The applicant is current being served by the MI Choice program or Medicaid nursing facility. Note whether they have been a program participant for at least one year and require ongoing services to maintain current functional status.

Source: MDHHS (2004a); MDHHS (2018d)

Box 6: MI Choice Eligibility Telephone Screening (2004-2012)

The questions on the screening include:

1. In the last 7 days, has the person needed human assistance in moving around in bed, transferring from bed to chair or wheelchair, or standing, toileting or eating?
2. (A) In the last 7 days, has the applicant had any difficulty in remembering things significant to daily life, or remembering to take scheduled medications? (B) In the last 7 days, has the applicant had any difficulty making decisions regarding tasks of daily life —their decisions were poor or they relied on someone else to make decisions for them?
3. In the last 14 days, has the applicant been examined by a physician, practitioner or authorized assistant which resulted in at least 1 physician visit and 4 physician order changes, or 2 physician visits and at least 2 physician order changes? (This does not include a routine health maintenance visit.)
4. Is the applicant currently being treated for any of the following conditions: diabetes, stage 3-4 pressure sores, intravenous or parenteral feedings, intravenous medications, end of life care (life expectancy less than 6 months), daily tracheostomy care, daily respiratory care, daily suctioning, pneumonia, daily oxygen therapy, daily insulin with 2 order changes, peritoneal or hemodialysis?
5. Has the applicant been scheduled to receive, or is receiving, speech, occupational, or physical therapies AND continues to require skilled rehabilitation therapies?
6. Has the applicant had any problems with any of these behaviors in the last 7 days: wandering, verbal or physical abuse, socially inappropriate behavior, resists care, hallucinations, or delusions?

Source: MDHHS (2006)

Box 7: Home Help ADL Dependence Scale (2013-2023)

1. Independent: Performs the activity safely and with no human assistance.
2. Verbal assistance: Performs the activity with verbal assistance such as reminding, guiding, or encouraging.
3. Some human assistance: Performs the activity with some direct physical assistance and/or assistive technology.
4. Much human assistance: Performs the activity with a great deal of human assistance and/or assistive technology.
5. Dependent: Does not perform the activity even with human assistance and/or assistive technology.

Source: MDHHS (2021)

Box 8: Nursing Facility Level of Care Determination (NFLOCD) Form Responses (2004-2023)

In order to meet a nursing facility level of care, the applicant must warrant the following responses for at least one door on their NFLOCD assessment:

- Door 1 - Applicant must score at least 6 points
- Door 2 - The applicant must score under one of the following
    1. 'Severely impaired' in decision making
    2. 'Yes' for memory problem, and decision making is 'Moderately impaired' or 'Severely impaired'
    3. 'Yes' for memory problem, and making self understood is 'Sometimes understood' or 'Rarely/Never understood'
- Door 3
    1. Over the last 14 days, at least one day in which the physician visited and examined the applicant AND at least 4 days in which the physician changed orders; OR
    2. Over the last 14 days, at least two days in which the physician visited and examined the applicant AND at least two days in which the physician changed orders.
- Door 4 - The applicant must score 'Yes' in at least one of the nine categories AND have a continuing need
- Door 5 - The applicant must have required at least 45 minutes of active speech therapy, occupational therapy, or physical therapy (scheduled or delivered) in the last seven 7 calendar days AND continue to require skilled rehabilitation therapies
- Door 6 - The applicant must have exhibited any one of the behavioral symptoms in at least four of the last seven calendar days (including daily) OR the applicant exhibited delusional
  thinking or clearly demonstrated having experienced hallucinations within seven calendar days AND met the PASARR requirement for nursing facility admission if they choose a residential setting of care
- Door 7 - The applicant must meet all three of the criteria to be determined service dependent

If the applicant does not qualify through one of the aforementioned doors, they may still qualify if they meet one of the following domain's criteria:

1. Frailty - Applicant demonstrates at least one of the following:
    - Performs late loss ADLs independently but requires unreasonable amount of time
    - Performance in activities impacted by shortness of breath, pain or weakness
    - At least two falls in the past month
    - Difficulty managing medications
    - Poor nutrition despite meal preparation services
    - ER visits for unstable conditions
2. Behaviors - Applicant has at least a one-month history of any of the following behaviors, and has exhibited two or more of these behaviors in the last 7 days:
    - Wandering
    - Verbal or physical abuse
    - Socially inappropriate behavior
    - Resists care
3. Treatments - The applicant has demonstrated a need for complex treatments or nursing care.

Source: MDHHS (2004a); MDHHS (2018d)

Notes: See Box 5, Nursing Facility Level of Care Determination (NFLOCD) Form Items, for more information on the assessment items that correspond to the above responses.

Box 9: MI Choice Wait List Priority Order (2004-2023)

Individuals are released from the wait list in the following priority order:

1. Children Special Health Care Service participants who are no longer eligible for state plan private duty nursing services because of age restrictions, but who continue to demonstrate a need for the service
2. Nursing facility transition participants who have resided in the facility for less than six consecutive months, excluding short term hospital stays
3. Qualified applicants diverted from an imminent nursing facility admission including any applicant with an active Adult Protective Services case who qualifies for and could benefit from the program's services; and
4. All other qualified applicants in chronological order by date of inquiry

Source: MDHHS (2007a); MDHHS (2018d)

Box 10: MI Choice Eligibility Telephone Screening (2013-2023)

The telephone intake call includes the following:

- Applicant's ability to complete ADLS and IADLs over the previous 3 days —Each task is scored using the following 0-4 point scale:
  - Independent —no help, set-up, or supervision = 0 points
  - Set-up help only = 1 point
  - Supervision —oversight, cueing = 2 points
  - More assistance needed = 3 points
  - Activity did not occur = 4 points
- Applicant's living arrangements, including whether there are hazards that make it difficult to move about the home, caregiver status and availability, etc.
- Applicant's chronic health problems, skin conditions, and current care received
- Behavioral issues, if applicable, such as whether they have been easily distracted had trouble paying attention, which is scored on the following 0-2 point scale:
  - Behavior not present = 0 points
  - Behavior present, consistent with usual functioning = 1 point
  - Behavior present, appears different from usual functioning (e.g.,, new onset or worsening)
- Questions for the interviewer based on their conversation with the applicant or with a third-party interviewee that knows the applicant over the previous 3 days, such as how well the applicant has made themselves understood, ability to make decisions, etc. —These questions are scored on either a 0-1 or 0-2 point scale depending on the question
- Financial questions relating to Medicaid enrollment, current income and assets, etc. These questions are optional.

Source: MDHHS (2014b)

Box 11: Home Health Services: Additional Dependence Information (2013-2023)

Medicaid covered services may be provided in the home only if circumstances, conditions, or situations exist which prevent the beneficiary from being served in a physician's office or other outpatient setting. These services are covered when they are medically necessary and ordered by the applicant's physician. The Michigan Department of Health and Human Services (MDHHS) identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs:

- New, onset, or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation)
- New or changed prescription medications (e.g.,, newly prescribed medications within the last thirty days or changed dosage, frequency, or route of administration within the last 60 days; including but not limited to diagnosis such as diabetes or hypertension)
- Recent hospitalizations (must include the date and reason for the hospitalization)
- Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility)
- Change in caregiver status, absence of a caregiver, or unstable caregiving situation
- Complicating factors (e.g., presence of Stage III or IV decubiti)

Source: MDHHS (2013b); MDHHS (2018e)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Active Status: Classification for MI Choice participants. Participants classified with Active status are those cases with the most difficult, unstable, or complex needs that require more intensive involvement. Supports coordinators classify cases as active when it is determined that the participant requires a reassessment every 90 days or more frequently when necessary.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Adult Services Comprehensive Assessment (MDHHS-5534): Comprehensive assessment for the Michigan Home Help program.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Case Management: MI Choice (called "supports coordination" under the program) benefit that provides service management for the enrollee. A coordinator will develop an individual plan of service, assist with access to benefits, and provide overall case management for a program beneficiary.

Community Spouse Resource Allowance (CSRA): Upper limit on disregarded assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Family Independence Agency (FIA): Directs the operations of public assistance and service programs, including Medicaid, through county family independence agencies, in every county in Michigan. This later became the Department of Human Services (DHS).

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Healthy Michigan Plan (HMP): Michigan's state-specific name for Eligibility Track 2c. ACA expansion adults. The HMP provides comprehensive health care coverage for a category of eligibility authorized under the Affordable Care Act (ACA). Individuals who are 19-64 years of age, have income at or below 138 percent of the federal poverty level, do not qualify for or are not enrolled in Medicare, do not qualify for or are not enrolled in other Medicaid programs, are not pregnant at the time of application, and are residents of the State of Michigan may qualify for this program.

Home and Community-Based Services for the Elderly and Disabled (HCBS/ED) Program: Michigan long-term care program providing home and community-based services to individuals aged 65 and above or disabled if under 65. This program was eventually renamed MI Choice in 2013 and transitioned to a managed care delivery system. The MI Choice program is still in operation today.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid mandatory health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home Help Program: Health benefit program administered by the Michigan Department of Health and Human Services (MDHHS) that provides personal care services to Medicaid beneficiaries who need hands-on assistance with Activities of Daily Living (ADLs) and assistance with Instrumental Activities of Daily Living (IADLs).

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Care Facility (ICF): A long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility (SNF), but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

interRAI Home Care Assessment System (iHC): An updated version of the Minimum Data Set Home Care (MDS-HC) assessment used for secondary evaluations of MI Choice applicants that was implemented in 2007. This system allows for increased international comparability of assessment data.

Maintenance Status: Classification for MI Choice participants. Participants classified with Maintenance status are more physically stable and less complex than active cases. Monitoring is required less frequently. Supports coordinators may designate maintenance case status when the participant's situation is currently stable. The participants level of frailty, risk, or illness determines that the participant requires a reassessment only every 180 days or more frequently when necessary.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: Groups that states are required to cover through Medicaid, which include low-income families, pregnant women, low-income children, and individuals receiving Supplemental Security Income (SSI).

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medical Needs Form (FIA-54A): Form that certifies an applicant's medical need for Home Help services under Michigan Medicaid. This form was later renamed the DHS-54A, after the Family Independence Agency (FIA) was renamed the Department of Health Services (DHS).

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

MI Choice: Michigan Medicaid long-term care program providing home and community-based services to individuals that are at least age 65, or 18-64 and disabled. This program was implemented as the new version of the Home and Community-Based Services for the Elderly and Disabled (HCBS/ED) program that provides HCBS through a managed care delivery system.

Michigan Department of Health and Human Services (MDHHS): Michigan's state-level agency that administers the state Medicaid program.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes. The MDS-home care (MDS-HC) was implemented for MI Choice in 1997, which is a standardized assessment system for home care that is compatible with national MDS standards for nursing facilities, allowing for a more integrated assessment system across long-term care programs.

Monthly Maintenance Needs Allowance (MMNA): Amount of disregarded income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Nursing Facility level of Care Determination (NFLOCD): The assessment, implemented in 2004, used to determine an applicant's medical eligibility for institutional care and HCBS programs, such as the MI Choice program.

Office of Services to the Aging (OSA): Michigan's designated state unit on aging. The OSA oversees Michigan's the administration of

older adult and family caregiver services.

Optional Categorically Needy: Groups that states may choose to cover through Medicaid, which may include aged and disabled individuals not receiving SSI and some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

Protected Income Level (PIL): The income limit Medically Needy applicants must spend down to meet. Federal rules require PILs to be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level in effect as of July 16, 1996.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Request for Prior Authorization of Medical Eligibility for Reimbursement for Skilled Nursing or Intermediate Care (R-19) form: Form used to document an individual's medical necessity for nursing home placement under Michigan Medicaid. This form was in use in 1992 but was replaced due to its subjectivity. It requires evaluators to document relevant medical status information of the applicant but allows them to subjectively determine the appropriateness of nursing home placement, without using objective level of care definitions.

Section 1115 Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Social Security Disability Insurance (SSDI): Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In Michigan, the payment is provided to all SSI recipients, including children, except those residing in medical facilities not certified under Medicaid. The state supplementation is added to the federal payment. Countable income is deducted first from the federal payment, and any income that remains to be counted after the federal payment has been reduced to zero is then deducted from the state supplementary payment.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See SSA (2011) and MDHHS (2023d) for more information.
2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023) for more information on these requirements.
5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in Michigan was 150
6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992. Countable assets/property are real and personal property that are counted to determine eligibility.
7. Our team has submitted a Freedom of Information Act (FOIA) request to the federal Centers for Medicare and Medicaid Services. The requested documents will provide information on the MI Choice program for the 1992 and 1995 chapters. Until then, these sections have missing information.
8. Our team has submitted a Freedom of Information Act (FOIA) request to the State of Michigan Archives. The requested documents will provide information on the eligibility process and requirements for state plan services in 1992 and 1995. Until then, these sections have missing information.
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the maximum MMNA as the community spouse's income. In 1995, the MMNA in Michigan was $1,871 per month.

10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $74,820 in 1995. Countable assets/property are real and personal property that are counted to determine eligibility.
11. The care management teams use professional judgement to determine whether applicants for program services meet the state's level of care criteria. The guidelines for exercise of professional judgement include definitions and examples of the types of care needed at skilled and intermediate levels in nursing homes. Key stakeholders commented that the guidelines are vague and the way in which professional judgment is exercised may lead to inconsistent application of the guidelines from one assessor to another (Urban Institute, 2001).
12. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999). After July 2007, the look back period was extended to 60 months for all assets (Michigan Senate, 2006).
13. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
14. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income up to a certain amount. The community spouse is allowed to keep a minimum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income. The MMNA in Michigan was $1,515 until July 1, 2004, and $1,562 effective July 1, 2004 (MDHHS, 2004d). Community spouses may only keep up to $2,319, the maximum MMNA for the 2004 calendar year.
15. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $92,760 in 2004 (MDHHS, 2004d). Countable assets/property are real and personal property that are counted to determine eligibility.
16. There is a 30 day per calendar year limit on respite services provided outside the home (MDHHS, 2007a).
17. The look back period is 60 months prior to the date of application for all assets (Michigan Senate, 2006).
18. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or receiving HCBS (e.g., MI Choice) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. The MMNA in Michigan was $2,898 until July 1, 2013, and $2,931 effective July 1, 2013 (LTC Commission, 2013; LTC Connection, 2014).
19. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $115,920 in 2013 (LTC Commission, 2013). Countable assets/property are real and personal property that are counted to determine eligibility. From 2014, this extended to spouses of individuals receiving HCBS (e.g., MI Choice).
20. Michigan is one of 7 states that has used a Section 1115 waiver, called the Healthy Michigan Plan (HMP), to implement Medicaid expansion in ways that differ from the terms in the ACA. HMP beneficiaries receive the standard state plan benefit package (KFF, 2016).
21. Michigan intended to implement a work requirement for applicants aged 19-62 under this track that would have required reporting work or other qualified activities unless exempt. This was challenged in litigation, and on March 4, 2020, a federal judge ruled that the work requirements were unlawful. The requirement was removed effective immediately and was never implemented (MDHHS, 2020).

Version information

Current Version: 1.0 (September 2023)

Version History

- 1.0 (September 2023): First version.