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Executive Summary

Everyone in Michigan should have access to quality healthcare and the long-term services and supports (LTSS) they need no matter their age, race, ethnicity, geographic location, or income. However, in its landmark report, Disrupting Disparities: The Continuum of Care for Michiganders 50 and Older, the AARP outlined numerous longstanding disparities in access to home- and community-based services (HCBS) and LTSS, social determinants of health and chronic disease burden, access to broadband services, and accessible and effective telehealth services throughout Michigan. It also made a clear and compelling case for how these disparities can be eliminated in proactive, positive ways.

The novel coronavirus (COVID-19) pandemic has only magnified the need to eliminate inequities in Michigan’s healthcare system for people over 50—and to do so with renewed urgency. The rapid growth of Michigan’s aging population, along with longstanding racial and ethnic biases and social inequality, have long posed challenges for local, state, and federal policymakers to equitably address older adults’ health and LTSS needs. Yet Michigan’s senior populations and people of color have been particularly impacted by the spread of COVID-19. Older adults are being hospitalized at far greater rates for COVID-19 than their 18-49 year old peers (over 35.2 percent for those aged 85 and older vs. 3.3 percent, respectively) and 95 percent of MI COVID-19 deaths are 50 and older, with a median age of 77 years.¹ Despite making up only 14 percent of Michigan’s population, African Americans account for 33 percent of confirmed COVID-19 cases and 40 percent of deaths in the state.²
These inequities need to be addressed—they are not inevitable. But there is cause for hope. The pages that follow explore affordable, short-term solutions to address disparities in four priority policy areas that will equitably improve the health and livelihoods of Michigan’s older adults and contribute to its economic comeback, both now and postpandemic:

- Access to HCBS
- Social determinants of health and chronic disease prevention
- Broadband access
- Quality telehealth services

If implemented, the recommendations in this report would individually accomplish the following:

- Allow seniors to live where they want and age in place, increasing access to services and supports at one third the cost of current options
- Reduce seniors’ likelihood of requiring nursing home care by 23 percent and hospitalization by 46 percent
- Save seniors nearly 25 percent in medical costs per year
- Increase access to high quality healthcare at reduced costs, while spurring business growth in rural and low-income communities
- Draw up to $335 million in untapped federal funds to Michigan, which would generate an estimated $517 million in gross domestic product (GDP) and 4,550 new jobs statewide

While their collective benefits have yet to be realized, the Disrupting Disparities recommendations provide a reliable path toward healthcare equity for all Michigan seniors, and are particularly urgent in light of the COVID-19 pandemic. Now, more than ever, is the time to take that path.
Disrupting Disparities

Access to Home- and Community-based Services

Economic turmoil places strain on underfunded home- and community-based services.

Economic turmoil, such as layoffs and furloughed work caused by COVID-19, limits funding for HCBS at multiple levels. Many primary caregivers are nonprofessionals, meaning they are a family member, friend, or neighbor of the person for whom they care. Michigan has an estimated 1,280,000 family caregivers who provide 1.2 billion hours of care to loved ones each year. On average, family caregivers' annual out-of-pocket expenses total nearly $7,000. These costs are higher for people of color. Hispanic and Latino/a caregivers spend 44 percent of their average income (equivalent to about $9,000 annually), African American families spend 34 percent, and whites spend 14 percent on caregiving expenses for their loved ones. The COVID-19 pandemic has increased the burden for family caregivers, particularly in households of color. In the short term, social distancing requirements limit the amount and types of care nonprofessional caregivers are able to provide, while in the longer term, the financial impact of COVID-19-related job loss for nearly 1.2 million Michiganders may negatively impact caregivers’ ability to afford the care their loved ones need. In many cases, HCBS are not available and institutional nursing home care—far more expensive and riskier during the COVID-19 pandemic—is also the only alternative to which families have access.

Federal and state budgets have also declined as a result of increased demands for social services and decreased revenue due to COVID-19-related economic downturn. In past recessions, each percentage-point increase in unemployment has led to a $41 billion drop in state tax revenues, plus an increase in Medicaid costs, for a total impact of $45 billion. This may, in turn, impact federal and state programming for HCBS. Eligibility for means-tested programs operated by state governments increases during economic downturns, putting pressure on spending for those programs. Given that the overwhelming majority of expenses are borne by

On average, family caregivers’ annual out-of-pocket expenses total nearly $7,000. These costs are higher for people of color.
Medicaid, whose funding structure is matched 60 percent on average by federal dollars, states’ fees increase as program enrollment rises.\(^{10}\) Additional Medicare funding from federal policymakers would alleviate individual states’ responsibility to fund the immediate public health emergency response. Further, federal funding would help offset increased program costs and potentially reduce the degree of spending cuts that could otherwise deepen and prolong a recession.\(^{11}\)

Low-income Michiganders of color experience worse access to quality healthcare services.

The emergent phase of the COVID-19 pandemic highlighted at least two stark disparities in access to quality healthcare. First, minority groups and marginalized communities are at higher risk of COVID-19 infection and transmission due to disproportionately less access to testing resources.\(^{12}\) Second, health systems in geographies with the highest proportion of nonwhite residents have also seen the highest COVID-19 care burden and corresponding strain on non-COVID-19-related staff and service provision.\(^{13}\) Thus, in the longer term, low-income people of color may also see decreased access to other unrelated healthcare services.

This would be concerning even if existing access to care was adequate for these communities’ needs. However, low-income people of color were already less likely than whites to be able to afford or receive quality care—the COVID-19 pandemic exacerbates the problems caused by this inequitable access. Michigan’s low-income communities and communities of color also have the highest rates of being uninsured. In 2017, only 7.8 percent of white Michiganders lacked healthcare coverage, lower than the 9.8 percent state average for all adults, and far lower than the 13.7 percent of black, non-Hispanic adults and 19.6 percent of Hispanic adults who lacked coverage.\(^{14}\) Whether insured or not, people of color were also likelier to visit minority-serving hospitals (MSHs) that had greater obstacles to proper care, successful recovery, and limited readmission.\(^{15}\) These obstacles include availability of primary care in the community, availability of financial resources, and adequacy of transitions of care.\(^{16}\)
Loss of life in nursing homes during COVID-19 highlights the longstanding need to rebalance Medicaid.

Seniors are at increased risk of contracting COVID-19 in nursing homes and other congregate settings. This risk is exacerbated by some nursing homes’ failure to adhere to infection prevention and control practices—their most cited error at the national level. After reviewing hundreds of federal inspections spanning the past three years, Bridge Magazine identified more than 80 Michigan nursing homes cited for infection control and prevention deficiencies. Advantage Living Centers, based in Roseville, Michigan, revealed that COVID-19 was found in seven of its homes in the metro Detroit area. Five of those seven homes were previously cited for infection deficiencies.

As of May 3, 2020, nearly 2,649 nursing home residents and staff in the City of Detroit were tested for COVID-19. About 39 percent had been infected, with 250 deaths reported, compared to a city-wide infection rate of 26 percent. According to data released by the Centers for Medicare & Medicaid Services, Michigan ranks sixth nationally in the number of nursing home resident deaths from COVID-19, with 1,654 nursing home resident deaths as of May 24, 2020. Michigan also ranks seventh nationally in the COVID-19 infection rates among nursing home residents with 118.7 cases per 1,000 residents.

This risk of new COVID-19 exposures is only exacerbated by lack of adequate home- and community-based rehabilitation services, which places demand on nursing homes to accept a revolving list of new rehabilitation residents. Nonetheless, lack of nursing home transparency hindered both family and public health efforts to track the spread of the disease until the federal government recently required states to begin reporting this data.

These challenges notwithstanding, institutionalized care costs three times more than the home- and community-based solutions most older adults in Michigan would prefer. The following recommendations are based in part on the AARP’s Disrupting Disparities report.

Michigan ranks seventh nationally in the COVID-19 infection rates among nursing home residents with 118.7 cases per 1,000 residents.

To provide greater access to quality elder healthcare services, ease the financial burden of Michigan’s family caregivers, and better safeguard its nursing home population, Michigan should:

- Rebalance Medicaid to alleviate the state’s growing portion of federal-state shared budget costs and increase access to comprehensive home-and community-based services,
• combinations of LTSS, and person-centered care coordination
Aim to spend no less than 50 percent of its Medicaid LTSS funding on HCBS for older adults by 2023
• HCBS spending represents the majority of LTSS spending in 30 states and the District of Columbia. On average, 57 percent of Medicaid LTSS expenditures nationwide were used for HCBS, while 43 percent were used for LTSS in institutional settings. In Michigan, however, only 43 percent of LTSS expenditures were for HCBS, while 57 percent were for LTSS in institutional settings—ranking Michigan 45th among states in its proportion of LTSS expenditures for HCBS.
• Michigan would save an estimated $2,176 per-member, per-month for every person requiring nursing facility-level care who remained in a community setting instead of a nursing facility.26

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• Enact a Family Caregiver Tax Credit in Michigan, which would help middle-class Michiganders address the significant financial challenges of family caregiving
• Provide increased access to respite care, which would encourage a steadier balance between caregivers’ work, caregiving, and additional responsibilities
Social Determinants of Health and Chronic Disease Prevention

Reducing senior hunger and diet-related chronic disease is associated with reduced healthcare costs and COVID-19 risk.

A healthy, balanced diet protects against chronic disease, but many older people of color face food insecurity—limited access to sufficient, safe, and nutritious food for an active and healthy life—making them more susceptible to both chronic disease and COVID-19.27 Food insecurity is a prevalent health issue that disproportionately impacts Michigan’s low-income, older people of color and is expected to grow significantly with this population in coming decades.28 In 2017, an estimated 7.6 percent of Michigan seniors were food insecure and 12.6 were marginally food secure.29 In 2018, food insecurity rates were higher than the national average for women living alone (14.2 percent), men living alone (12.5 percent), households with black, non-Hispanic (21.2 percent) and Hispanic (16.2 percent) heads of household, and households with incomes below 185 percent of the poverty threshold (29.1 percent).30 Among widowed people, 16.5 percent reported only marginal food security (nearly twice the percentage of married households) and among those with grandchildren living at home, over one in four (27.3 percent) reported only marginal food security (over twice the percentage of those without grandchildren in the home) in 2017.31 Over half (50.8 percent) of seniors with very low food security were renters.32

<table>
<thead>
<tr>
<th>Income below 185% of Poverty</th>
<th>29.1%</th>
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<tbody>
<tr>
<td>Black, non-Hispanic Head of Household</td>
<td>21.2%</td>
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<tr>
<td>Hispanic Head of Household</td>
<td>16.2%</td>
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<tr>
<td>Women Living Alone</td>
<td>14.2%</td>
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<tr>
<td>Men Living Alone</td>
<td>12.5%</td>
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Food-insecure seniors had lower nutrient intakes, were more likely to face depression, and were over two times more likely to be in poor or fair health compared to their food-secure peers.33 Food-insecure seniors were also more likely to have limitations in activities of daily living (ADL)
compared to their food-secure peers, the impact of which was roughly equivalent to aging fourteen additional years.\textsuperscript{34}

Food insecurity also contributes directly to diet-related chronic disease.\textsuperscript{35} In Michigan, older people of color disproportionately bear the state’s chronic disease burden, placing them at high risk for COVID-19 contraction and severe symptoms.\textsuperscript{36} This is doubly concerning, because people of color are also more likely than whites to live in multigenerational households, work for low wages, and rely on public transportation.\textsuperscript{37} During the pandemic, this means household members who commute to work, go grocery shopping, seek medical care, and perform other activities of daily living also put their older household members at even higher risk for contracting COVID-19 via indirect exposure.

In 2016, healthcare costs associated with food insecurity in Michigan were an estimated $1.8 billion—or $182 per capita on average—for the entire state population, a conservative estimate that accounts only for direct costs.\textsuperscript{38} Food-insecure individuals experienced a significantly greater number of emergency department visits, inpatient hospitalizations, and days hospitalized than food-secure individuals and higher healthcare costs.\textsuperscript{39} Food-insecure individuals had significantly greater expenditures than food-secure individuals for inpatient hospitalizations ($471.48 per year) and prescription medications ($779.36 per year).\textsuperscript{40} They also had significantly greater estimated mean annualized healthcare expenditures ($6,072 versus $4,208) and an extra $1,863 in annual healthcare expenses than those who did not experience food insecurity.\textsuperscript{41} This was particularly true for older adults; on average, food-insecure older adults’ healthcare costs were 11 percent higher than food-secure older adults, with or without chronic diseases.\textsuperscript{42}

**Food access increases seniors’ quality of life during and after COVID-19.**

Michigan received roughly $7.5 million in expanded federal funding for home-delivered and congregate meals through the Families First Coronavirus Response Act—a crucial lifeline for the nearly 100,000 older adults served by these programs.\textsuperscript{43} This is a positive step, yet represents a minor fraction of Michigan’s 418,320 seniors, those age 60 or older, living at or below 150 percent of poverty and at risk of food insecurity.\textsuperscript{44} These households could benefit significantly from the federal Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), the
United States’ primary nutrition assistance program and an important resource for many Michigan seniors. Low-income SNAP participants save nearly 25 percent in medical costs per year, or about $1,400, compared to nonparticipants. Compared to nonparticipants, SNAP participants with hypertension and coronary heart disease save even more. Low-income older adults who participate in SNAP are 23 percent less likely to require nursing home care and 46 percent less likely to be hospitalized, compared with nonparticipants.

The percentage of SNAP-participating households with older individuals has increased more than ten percentage points over the past 25 years. In 1993, less than 16 percent of SNAP households included one or more elderly members. By 2018, it increased to 26 percent. While overall SNAP participation has decreased since fiscal year (FY) 2013, the number of older adult participants continues to grow. Nonetheless, participation among eligible seniors is low. Slightly more than half (51 percent) of eligible Michigan seniors participated in 2015 and less than half (48 percent) of eligible seniors participated nationwide in 2017. What’s more, Michigan seniors not currently enrolled in SNAP did not benefit from COVID-19 emergency allotments granted to their SNAP-participating peers through a United States Department of Agriculture (USDA) waiver obtained by the state. Even for those who do have SNAP, access to grocery stores is low (particularly for low-income seniors of color) and, at the time of this writing, those seniors with broadband internet cannot purchase food online through SNAP during COVID-19 because Michigan is not one of several states piloting online purchasing.

The following recommendations are based in part on the AARP’s Disrupting Disparities report.

To alleviate chronic and emergent COVID-19 health risks (and associated healthcare costs) to Michigan seniors, Michigan should:

- Increase SNAP participation among households with seniors
- Would result in a positive, direct fiscal stimulus to Michigan’s more than 9,000 SNAP retailers with a corresponding economic impact to the state of $1.54 for every SNAP dollar spent, not including cost savings due to improved health and reduced healthcare costs, all at negligible cost
• In 2017, an estimated 270,419 Michigan seniors were eligible for, but not participating in SNAP, forgoing up to an estimated $335 million in SNAP dollars. Were each of these seniors to participate in SNAP, it would generate up to an estimated $517 million in additional economic activity (GDP) statewide, including up to 4,550 new jobs. This includes 1,493 new jobs in trade and transportation, 362 in foodservices and accommodations, and 161 in agriculture.55

In 2017, an estimated 270,419 Michigan seniors were eligible for, but not participating in SNAP, forgoing up to an estimated $335 million in SNAP dollars.

• Obtain a waiver to implement online SNAP purchasing as soon as federally allowable and expand access to broadband internet to ensure that SNAP-participating seniors can order groceries for pickup or home delivery online.
**Access to Broadband**

**Greater access to broadband would improve lower-income Michiganders’ quality of life during quarantine and beyond COVID-19.**

Currently, both rural and low-income Michiganders are negatively impacted by a lack of access to broadband or are unaware of how to obtain it. As of 2018, “an estimated 368,000 rural Michigan households do not have access to broadband [and] 35 percent of Michigan households do not subscribe to a fixed, terrestrial broadband service.” Further, Michigan ranks 34th in a nationwide comparison of households that subscribe to broadband service. Lack of broadband access for older adults is both a potential risk factor for contracting COVID-19 and for suffering from isolation during COVID-19 quarantines. Inability to access telehealth requires older adults to travel for healthcare, risking exposure to COVID-19. Yet mandatory social distancing can also worsen feelings of isolation, which one in four elders reported feeling prior to the COVID-19 outbreak. “Social isolation and loneliness have been linked to many physical and mental health problems including heart disease, diabetes, anxiety, and depression. The health damage caused by isolation and loneliness is estimated to increase the risk of early death by 26 [percent] and is estimated to cumulatively cost Medicare an additional $6.7 billion each year.” Greater access to broadband for older adults can solidify familial and social relationships, helping to deflect health complications made worse by isolation and depression, thus also reducing potential healthcare costs.

**Michigan ranks 34th in a nationwide comparison of households that subscribe to broadband service.**

**Broadband investment will improve Michigan’s economy and allow older adults to age in place.**

Telecommunications investment has an impact far beyond the scope of the industry itself, promoting growth in adjacent industries and creating new industries. Lower-income Michiganders will have greater access to job postings and applications as well as an increased likelihood of job matching. Overall, “Michigan would see a $2.5 billion boost in economic activity by connecting the more than 1.3 million households that don’t subscribe to a broadband connection. The boost would equal $1,850 per household...”
and would come mainly through greater small business activity, increased tourism and more farm revenue. About 12,000 jobs would be created or retained through greater use of broadband."64 A stronger economy, specifically in rural places, decreases the risk of rural flight and encourages medical systems to remain and flourish.65 If access to hospitals and primary care physicians grows, telehealth opportunities may also increase and have the potential to become less expensive over time.66 With adequate healthcare available by reliable broadband connection, older adults will be more likely to be able to age in place.

Increasing Michigan broadband access could boost economic activity by $2.5 billion

Expanding legislation to mandate that government programs subsidize monthly subscription costs will make broadband more accessible to lower-income Michiganders. The cost of broadband subscriptions must be reduced to achieve greater broadband subscription across Michigan households. Public, private, and nonprofit entities’ partnerships are essential in rural areas “too sparsely populated to draw interest from major telecommunications providers.”67

The following recommendations are based in part on the AARP’s Disrupting Disparities report.

To ensure greater access to broadband and ultimately improve the lives of Michiganders and the state’s economy, Michigan should:

• Work with the Michigan Public Service Commission to mandate and implement broadband expansion to areas with limited geographic or financial access to healthcare in Michigan, partnering with health systems to assess practical opportunities to expand the use of telehealth resources in these areas
• Pass state legislation to allow municipalities to create special assessment districts for communications infrastructure, including broadband and high-speed internet
  • Municipalities can use special assessments for the construction, improvement, and maintenance of communications infrastructure in specific areas of the community currently lacking high-speed internet, allowing potential public- private partnerships to flourish
• Collaborate among community partners (the Michigan Consortium of Advanced Networks, the Disrupting Disparities Task Force, and others) to educate older consumers on the use of broadband technology and applications to achieve social, personal, and economic benefits, including the use of telehealth technologies
Access to Telehealth Services

Greater telehealth access may help curb the spread of COVID-19 and decrease strain on health systems in lower-income communities.

Without adequate broadband access, lower-income individuals may not have access to telehealth resources, forcing them to leave their homes for in-person healthcare appointments and placing them at increased susceptibility for contracting COVID-19.

Increased broadband access “reduces resource use across the already stressed health-care infrastructure, improves access to care, and at the same time minimizes the risk of direct person-to-person transmission of the infectious agent.” By implementing greater use of telehealth into its programming during a four-year period, Spectrum Health System’s Grand Rapids-area patients saved more than 900,000 miles in trips to healthcare providers.

When considering patients who use public transportation or who must travel repeatedly to seek care for chronic health issues, this reduction in travel exponentially reduces COVID-19 exposure risk for both patients and healthcare staff.

The current healthcare crisis has demonstrated a need to implement robust telehealth platforms across healthcare practices to keep up with demand during and after COVID-19. Establishing telehealth as a viable alternative to in-person patient visits can save patients time and money, as well as limit the spread of contagious illnesses, all while continuing to support the healthcare economy. Compared to patients traveling to in-person appointments, video conferencing is potentially safer and more time-efficient, especially for older adults who struggle with travel and mobility. Further, remote consultations alleviate the real-time complication of overburdened waiting rooms, where space is needed for acute, as opposed to routine, medical concerns. To effectively implement a telehealth system, healthcare administrators must encourage clinicians to perceive telehealth as an “effective, safe, and normal” method of diagnosing and treating medical issues.

Spectrum Health System’s Grand Rapids-area patients saved more than 900,000 miles in trips to healthcare providers during a four-year period using telehealth.
Given that telehealth consultations disrupt current procedures and require time and training for clinicians to learn, it is unlikely to be successfully deployed as an emergency solution during a health crisis such as the COVID-19 pandemic. Yet telehealth training and education can and should be added to curricula and postgraduate accreditation opportunities in the short term.

Continuing to remove cost barriers to telehealth access will benefit Michigan’s vulnerable populations.

On March 17, the Centers for Medicare and Medicaid (CMS) announced that it would lift additional restrictions on telehealth paid for through Medicare. Previously, telehealth visits through Medicare were restricted to older adult patients living in rural areas (who had an already established relationship with a provider) and for telehealth services that took place in a rural healthcare facility. Yet despite this advancement, additional hurdles to telehealth access remain.

One of these hurdles is insufficient broadband infrastructure to support telehealth in rural locations and urban areas like Detroit—a city that was deemed the “worst-connected” city in the U.S. in a 2015 study. Only about 50 percent of Detroit residents have broadband access, compared to 97 percent of Wayne County residents. In a city that is nearly 80 percent black, the lack of broadband access for Detroiters reflects racial and economic disparities in the availability and affordability of high-speed internet. Considering that “nearly 40 percent of the city’s population lives at or below the federal poverty line, compared to 15 percent statewide,” the cost of broadband can pose a significant barrier to greater access.
Combined with lower rates of healthcare access in African American and Hispanic households, the costs of broadband access and telehealth are also greater barriers to lower-income communities of color. Hispanic adults (19.6 percent) and black, non-Hispanic adults (13.7 percent) both reported a higher prevalence of no healthcare coverage than white, non-Hispanic adults (7.8 percent). To effectively improve low rates of healthcare access among communities of color, CMS should consider permanently lifting restrictions in accessing telehealth services.

The following recommendations are based in part on the AARP’s Disrupting Disparities report.

To ensure accessible and affordable telehealth among those at highest risk of COVID-19, Michigan should:

- Expand access to broadband in all underserved areas to eliminate barriers to telehealth services
- Pass state legislation to include Michigan in the Interstate Nurse Licensure Compact
- Allowing nurses to become licensed in several states increases patients access to healthcare through telehealth services and frees up front line nurses to continue their important tasks.

- Harness the promise of telehealth technologies through reforms to both private payer and state Medicaid reimbursement policies for home telehealth, including:
  - Medicaid reimbursement for remote patient monitoring
  - Allowing a patient’s home to be an originating site
  - Implementing education and training for telehealth technology
Notes


5 AARP. October 2018. Disrupting Disparities.


AARP. October 2018. Disrupting Disparities.


Disrupting Disparities


40 Seth A. Berkowitz et al. 2017. Impact of Food Insecurity and SNAP Participation.

41 Seth A. Berkowitz et al. 2017. Impact of Food Insecurity and SNAP Participation.


55 Patrick Canning and Brian Stacy. July 2019. The Supplemental Nutrition Assistance Program; Analysis by Public Sector Consultants: Eligibility and benefit estimates were calculated based on actual average monthly household benefits for SNAP participants aged 60 and older, by household size. The likely eligible population was calculated based on the total number of Michigan seniors aged 65 years or older with incomes below 200 percent of the federal poverty threshold who were not participating in SNAP during calendar year 2017. Economic impact was calculated based on national multipliers established by Canning and Stacy (2019) and may be impacted by COVID-19 related changes to the economy.

56 AARP. October 2018. Disrupting Disparities.

57 AARP. October 2018. Disrupting Disparities.


64 AARP. October 2018. Disrupting Disparities.


69 AARP. October 2018. Disrupting Disparities.


76 AARP. October 2018. Disrupting Disparities.

77 AARP. October 2018. Disrupting Disparities.

78 AARP. October 2018. Disrupting Disparities.
