Michigan Family Impact Seminars

Supporting Children and Families While Controlling Medicaid Costs

Briefing Report No. 2005-1

MICHIGAN STATE UNIVERSITY

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Executive Summmary

Laura Bates

The Medicaid Challenge

In this brief, three experts discuss issues related to the containment of rising Medicaid costs, including supporting family caregivers as an alternative to nursing home care and preventing childhood obesity.

Medicaid is a publicly funded heath insurance program that provides health coverage to some 52 million low-income children, families, individuals with disabilities, and the elderly. It fills gaps in Medicare coverage for some 7 million low-income seniors, particularly for prescription drugs and long-term care. In Michigan, Medicaid provides coverage for approximately 1.4 million people, including almost 28% of the state's children.[1] In Detroit the number of children covered rises to 56%.[2] Therefore, Medicaid is an important safety net service for vulnerable individuals, particularly in difficult economic times when family wage earners are laid off from jobs and more families fall into poverty.

In Michigan, Medicaid provides coverage for approximately 1.4 million people, including almost 28% of the state's children.[1]

As a result of both increased enrollment and increased costs, Medicaid spending continues to grow, putting pressure on already stressed state budgets. In fact, Medicaid is the second largest item in most state budgets after education. Medicaid makes up about 16% of state budgets nationally, and in Michigan almost one quarter of state General Fund/General Purpose revenue goes to Medicaid. States are looking for ways to balance containing cost increases with maintaining a safety net for vulnerable populations.

A National Challenge: How States Are Trying to Control Medicaid Costs (And Why It's So Hard) — Vernon K. Smith

Dr. Smith presents an overview of the Medicaid situation nationally, the key factors that are driving cost increases and the strategies states are using to try to control costs. To understand the key issues, one must first know something about how Medicaid is funded and what current spending patterns are.

Medicaid is funded by state dollars that are matched by federal dollars on an open-ended basis, so that increases in state spending bring increased federal dollars into the state. States must design and administer the program according to federal rules, but within those rules states have some flexibility on eligibility, covered services, payment rates for providers, and other key issues such as use of Managed Care Organizations. They can also apply for "waivers," i.e., deviations from the federal rules.

Although the majority of enrollees are children and families, elderly and disabled persons account for 70% of Medicaid spending. Medicaid is a key player in the health care system, paying for 18% of prescription drugs and almost half of nursing home care costs in the United States. Costs continue to increase; in FY 2004 the average increase was 9.5%. Key factors driving cost increases include: enrollment growth, increased costs of prescription drugs, and the rising costs of medical and long-term care.

Strategies to Control Costs

For the past several years, the economic downturn has simultaneously reduced state revenues and increased enrollment in Medicaid. Most states have adopted a comprehensive set of strategies to control costs that fall into the following general categories:

- Reducing or freezing payments to providers
- Controlling pharmacy costs
- Reducing benefits
- Reducing or restricting eligibility

Strategies to Control Costs

· Reducing or freezing payments to providers

· Controlling pharmacy costs

· Reducing benefits

· Reducing or restricting eligibility

· Increasing co-payments required of enrollees

· Implementing disease management programs

· Implementing cost controls for long term care

· Targeting fraud and abuse

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New challenges to cost containment

In spite of these efforts, several new challenges will affect states' abilities to contain Medicaid spending growth in the near future:

· Expiration of federal fiscal relief
· Increased federal scrutiny of special financing arrangements
· Implementation of the Medicare Part D prescription drug benefit

In spite of these efforts, several new challenges will affect states' abilities to contain Medicaid spending growth in the near future:

- **Expiration of federal fiscal relief** – With the expiration of enhanced federal matching rates for Medicaid spending that provided temporary assistance in 2003 and 2004, state spending on Medicaid will grow enormously in 2005 (an average 11.7% increase, compared with 4.8% in FY 2004).
- **Increased federal scrutiny of special financing arrangements** Many states, including Michigan, have used special financing arrangements to deal with Medicaid shortfalls during the recent period of fiscal crisis. As the federal Centers for Medicare and Medicaid Services increases scrutiny of these arrangements, states that have relied heavily on them will feel the impact.
- **Implementation of the Medicare Part D prescription drug benefit** – The new Medicare drug benefit, scheduled to take effect in January 2006, will place increased responsibility on states for those eligible for both Medicare and Medicaid. A "**clawback"** provision will require states to make payments to the federal government to help finance the benefit for those with dual eligibility and may also require states to enroll them in the new benefit.

What is the outlook for the future?

At the federal and state levels, the recent fiscal crisis has increased interest in restructuring the federal Medicaid law. States are taking two different approaches to Medicaid: 1) some states are seeking to cut costs further through Section 1115 waivers that allow them the flexibility to place limits on enrollment and benefits, and 2) a few are beginning to view Medicaid as an effective means to address the issue of the uninsured and to expand coverage. The direction that future state/federal discussions take will have a large impact on the ability of the program to serve as part of the safety net for vulnerable populations.

Family Caregivers: The Backbone of Long-Term Care – Lynn Friss Feinberg

The estimated value of this informal care is $257 billion annually.

Although nursing home care is the major expenditure for persons requiring long-term care, the overwhelming majority — 78% — of frail elderly and disabled persons who need long-term care are maintained in their own homes with the support of family members and friends. The estimated value of this informal care is $257 billion annually, 2.8 times the value of nursing home care. Policymakers are beginning to recognize this value by supporting the needs of family caregivers.

Strategies to support caregivers

Feinberg reviews four strategies that states are using to support family caregivers:

- **Bolster direct services** – States are using a combination of state and federal funds to enhance services that support family caregivers in their caretaking role. Federal funding comes from the National Family Caregiver Support Program (NFCSP) and through Medicaid home and community-based waiver programs. Primary services include:
  - **Respite care** (temporary alternative care)
  - **Supplemental services** (assistive devices, consumable supplies, home modifications)
  - **Information, counseling and support groups**

- **Promote consumer direction and direct financial compensation to caregivers** – These approaches offer increased control and choice to people who use services. The primary approaches to increasing consumer control include:
  - **Vouchers** that family and caregivers can use to purchase supplemental services
  - A variety of **respite care options**
  - **Direct payments to family caregivers**
- **Expand tax incentives** – States can offer **tax deductions** or **tax credits** for expenses incurred by family caregivers.
- **Expand workplace family and medical leave policies** – Some states have expanded the federal Family and Medical Leave Act of 1993 to include:
  - **Workplaces of less than 50 employees**
  - **Coverage for a greater range of needs**
  - **Expanded definitions of "family"**
  - **Longer leave periods**
  - **Offering *paid* leave**

Strategies to support caregivers

• Bolster direct services

• Promote consumer direction and direct financial compensation to caregivers

• Expand tax incentives

• Expand workplace family and medical leave policies

Key findings on family caregiver support programs

A recent 50-state survey of family caregiver support programs found that states are playing a major role in supporting family caregivers. Key findings include:

- Publicly funded services are increasing but access is uneven within states and across states
- The NFCSP is key to enhancing the scope of services but is inadequately funded
- Uniform assessment of caregiver needs is recognized as important but approaches vary
- States' views differ on the importance of caregiver services and the need to integrate them into the home and community-based service system

What can states do to promote caregiver support?

The Family Caregiver Alliance made the following recommendations:

- **Use federal Systems Change Grants to promote a "family systems approach" to home and community based services**
- **Adopt uniform assessment of caregiver needs in all programs that provide caregiver support**
- **Advocate for uniform data collection and reporting standards in NFCSP and other caregiver support programs**
- **Conduct a statewide public awareness campaign on family caregiving**
- **Invest in staff training and technical assistance**

Preventing Childhood Obesity: Controlling Medicaid Costs – Nigel Paneth, M.D.

Health care costs related to obesity in the United States are nearly $120 billion annually or about 7% of total health care costs. As one half of all obesity-related health care costs are underwritten by Medicaid and Medicare, the current increase in obesity will have a significant impact on future growth of Medicaid spending. In addition, the experience of chronic diseases related to obesity will have a significant impact on the quality of life of the affected individuals.

Recent increases in the incidence of overweight and obesity among U.S. adults and children represent (except for post-famine periods) probably the largest across-the-board weight gain in human history. Over the past two decades the prevalence of overweight children has doubled in most age categories and has increased fourfold among children 6 to 11 years of age. Obesity is associated with substantial increases in risks for chronic diseases such as diabetes, osteoarthritis, and cardiovascular disease.

Health care costs related to obesity in the United States are nearly $120 billion annually or about 7% of total health care costs.

Obesity is caused by an excess of "calories in" over "calories out." So, what do we know about preventing obesity?

Interventions can be at the individual level or the community level (ecological interventions).

At the **individual level**, we can:

- Promote awareness of the benefits of adopting good diet and exercise habits
- Three promising programs for children and youth currently under study are:
  - HIP HOP to Health, which targets minority children in Head Start
  - Go Girls!, which targets overweight teen girls to promote better eating and exercise patterns
  - GEMS, which seeks to prevent excessive weight gains among girls during puberty
- Good quality evidence on the effectiveness of intervention programs is lacking; therefore no conclusions from existing studies can be generalized to larger groups. A national strategy awaits further evidence.

Community-level interventions that modify aspects of the environment to promote better health are more effective in addressing population trends than are interventions at the individual level.

Community-level interventions that modify aspects of the environment to promote better health are more effective in addressing population trends than are interventions at the individual level. (Examples of effective community-level health interventions include water chlorination and fluoridation.) Suggestions for community-level obesity prevention strategies include:

- **Modifying marketing targeted toward children** that encourages consumption of high-fat, high-calorie foods.
- **Municipal planning around the built environment**, including
  - Designated bike lanes on new or repaired roads
  - Requiring sidewalks in new residential areas
  - Converting abandoned rail beds to walking/biking trails
  - Providing safe approaches for pedestrians and cyclists at shopping malls
  - Reducing urban sprawl by promoting neighborhoods with facilities within walking distance
- **Worksite modifications** such as
  - Providing safe areas to walk or exercise
  - Providing bike racks
  - Providing showers (for those who exercise before work or during lunch)

What can policymakers do now?

- First, recognize that we do not yet know exactly what to do to prevent obesity
- Encourage a variety of community approaches to address calories in and calories out
- Advocate for controls at the national level on TV advertising directed at children's food consumption
- Evaluate all interventions to assess their effectiveness

Other Information

Encourage a variety of community approaches to address calories in and calories out

Supplementary chapters put a **Michigan focus** on the issues, describing activities in the state: (1) to **support family caregivers,** and (2) to **prevent childhood obesity** by promoting healthy eating and physical activity.

Snapshots of Promising Programs presents brief summaries of innovative programs from across the country to support family caregivers or to prevent/ treat obesity among children and youth. These programs have some evaluation data to support their effectiveness.

Glossary defines technical terms used in the report.

Additional resources offers sources for obtaining more detailed information or in-depth analysis of material presented at the seminar.

Introduction

Laura Bates

Mr. Z. is a middle-aged resident of a mid-sized city who was diagnosed with Multiple Sclerosis which has progressed very rapidly. A former factory supervisor, Mr. Z. is now challenged and exhausted by virtually every activity of daily living. Despite his very significant and progressive disability, Mr. Z. feared and dreaded nursing home placement because it would take him away from his three children. Though normally a genial and optimistic person, Mr. Z. repeatedly stated he would refuse food and water if forced to enter a nursing home. He cried with joy when he learned that he would be able to stay in his home and receive services from the MI Choice program.

Ms. M. is an elderly woman who suffers from Alzheimer's Disease. Her devoted husband of many years took care of her until his own declining health forced him to place her in a nursing home. Both Mr. and Mrs. M. wanted only to spend their last days together in their own home. Because of home and community-based services, they were able to do so.

As these stories illustrate, Medicaid can make important improvements in the quality of life for elderly and disabled citizens of Michigan. However, although we tend to think of Medicaid as a program primarily for poor elderly persons, in fact, Medicaid has become a major player in other aspects of the health care system. It provides coverage for over 53 million people nationwide and 1.4 million in Michigan.

Although we tend to think of Medicaid as a program primarily for poor elderly persons, in fact, Medicaid has become a major player in other aspects of the health care system.

In the area of maternal and child health, Medicaid pays for:

- Prenatal care and delivery for 37% of U.S. births
- Comprehensive health coverage for 1 in 4 children

In relation to care for seniors and people with disabilities, Medicaid:

- Covers 2/3 of nursing home patients
- Pays for home and community based services
- Fills gaps in Medicare coverage for 7 million low-income seniors

The growth in Medicaid spending is a cause for concern among states, as spending grew at an annual rate of 9.5% in FY 2004. Although this is down from the average annual growth of 11.9% in FYs 2000-2002, the Medicaid budget is constraining state spending for a number of other programs. In Michigan, Medicaid made up 28% of general fund spending in FY 2004.

The growth in Medicaid spending is a cause for concern among states, as spending grew at an annual rate of 9.5% in FY 2004.

What can policymakers do to slow the growth of Medicaid spending? States are trying various short- and long-term strategies to slow the growth of spending. Some of these will be discussed in this brief. Dr. Vernon Smith (Health Management Associates) presents the most recent data on Medicaid spending and the strategies states are using in the short term to contain growth. Ms. Lynn Friss Feinberg (National Center on Caregiving) talks about programs that offer alternatives to nursing home care to reduce spending and support families in their own homes. Finally, Dr. Nigel Paneth (College of Human Medicine, MSU) discusses long term cost control strategies through prevention of childhood obesity to reduce the risks of chronic disease in the population. The brief describes Michigan programs to address these concerns.

Vernon K. Smith, Ph.D., Principal of Health Management Associates, focuses on issues related to Medicaid, Medicare, SCHIP, state budgets and trends in the health care market place. He has authored several reports on the effects of the economic downturn on Medicaid, on enrollment trends in Medicaid and SCHIP, how states are responding to budget shortfalls and state preparations for the Medicare prescription drug benefit. Dr. Smith has spoken on these issues before many national and state audiences, including the National Governors Association, the National Conference of State Legislatures, professional associations of state administrators, the National Health Policy Forum, committees of the U.S. Congress, and Medicaid reform groups. Before joining HMA, Dr. Smith served as Medicaid director and as budget director for the human services agency during his 30 years of public service in Michigan. He holds a Ph.D. degree in economics from Michigan State University.

A National Challenge: How States Are Trying to Control Medicaid Costs (And Why It's So Hard)

Vernon K. Smith, Health Management Associates

Introduction

Medicaid plays a major role in our nation's health care system, paying for nearly half of nursing home care, and 18% of prescription drugs.

As states entered Fiscal Year 2005, they were faced with a mix of good news and bad news. After three years of intense fiscal stress, most states were anticipating an improved revenue picture. At the same time, several factors continued to place pressure on states to contain Medicaid costs. This report is based on a 50-state survey of Medicaid administrators that was conducted in the summer of 2004 concerning their states' Medicaid spending growth and cost containment strategies.

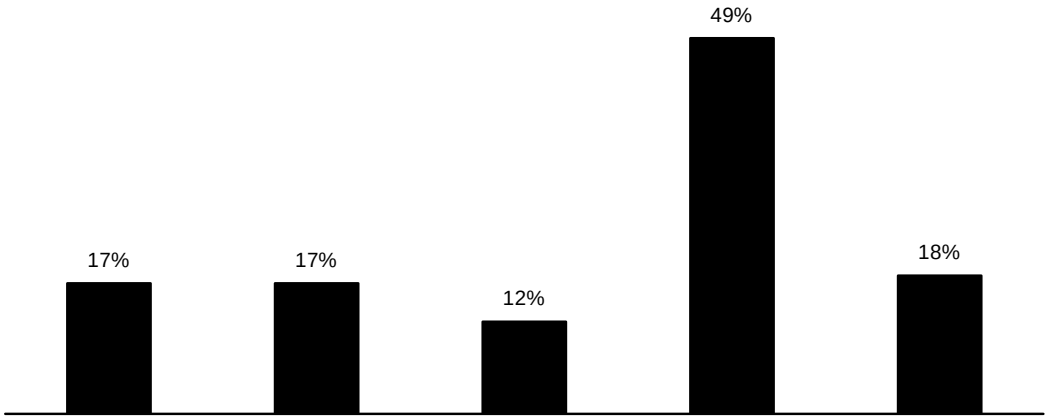
What is Medicaid and what role does it play in our health care system?

Medicaid is a publicly funded health insurance program that provides coverage to low-income children, families, seniors, and people with disabilities. Medicaid also fills gaps in Medicare coverage for many low-income seniors, particularly for prescription drugs and long-term care. It is the largest publicly funded health insurance program, providing health and long-term care coverage to 52 million low-income children and adults in FY 2004, compared to 42 million covered by Medicare. Medicaid also supplements Medicare coverage for 7 million low-income seniors and people with disabilities who are enrolled in both programs. [In **Michigan**, Medicaid provides coverage to approximately 1.4 million persons.[1]]

As Figure 1 shows, Medicaid plays a major role in our nation's health care system, paying for nearly half of nursing home care, and 18% of prescription drugs.

Figure 1: Medicaid's Role in the Health Care System, 2002

Medicaid as a share of national personal health care spending:



	Total Personal Health Care	Hospital Care	Professional Services	Nursing Home Care	Prescription Drugs
Total National Spending (billions)	**$1,340**	**$486.5**	**$501.5**	**$103**	**$162**

SOURCE: Levil, et al, 2004. Based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

How does Medicaid work?

States must design and administer the program according to the federal rules. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide on some covered services, and set payment rates for providers. States decide key policies, such as use of managed care systems; they also may provide coverage for "optional" services beyond the required core services (e.g., non-emergency dental and vision coverage for adults). The federal government sets minimum requirements, authorizes deviations ("waivers") from these requirements, and audits expenditures and performance.

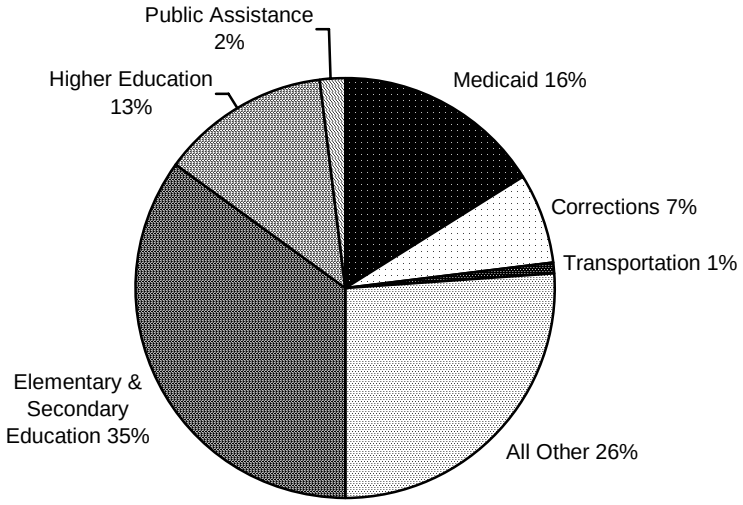
Medicaid is jointly funded by states and the federal government, with the federal government matching state spending on an open-ended basis. The federal match rate, known as the federal medical assistance percentage (FMAP), varies by state from 50 to 77 percent. [In **Michigan**, the federal Medicaid matching rate is about 56.7[1] percent.]

Because of the matching formula, state spending brings increased federal dollars into the state, providing an incentive for states to increase funding for health and long-term care services. On average, states spend about 16% of their state budgets on Medicaid, making it the second largest program in most state budgets, after education (see Figure 2). [In **Michigan**, almost one quarter of state General Fund/General Purpose revenues go to Medicaid.[2]]

Because of the matching formula, state spending brings increased federal dollars into the state, providing an incentive for states to increase funding for health and long-term care services.

1. FY 2004-05

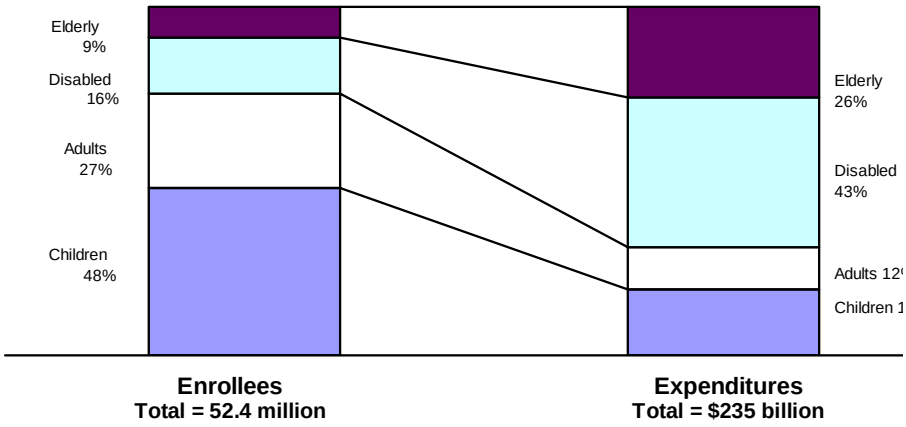
Figure 2: State Medicaid Spending as a Percent of General Fund Expenditures, 2002



Total State General Fund Spending=$496 Billion

SOURCE: National Association of State Budget Officers, 2002 State Expenditure Report, November 2003.

Figure 3: Medicaid Enrollees and Expenditures by Enrollment Group, 200



Expenditure distribution based on Congressional Budget Office data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.
SOURCE: Kaiser Commission estimates based on CBO and Office of Management and Budget data, 2004.

Where does most Medicaid spending go?

Medicaid expenditures vary for the different populations served. Although low-income children and families represent about three-fourths of Medicaid beneficiaries, they account for only one third of the expenditures (see Figure 3). On the other hand, elderly and disabled individuals, who represent just one quarter of the beneficiaries account for 70 percent of the expenditures, reflecting their intensive use of acute and long-term care services.

Elderly and disabled individuals, who represent just one quarter of the beneficiaries account for 70 percent of the expenditures.

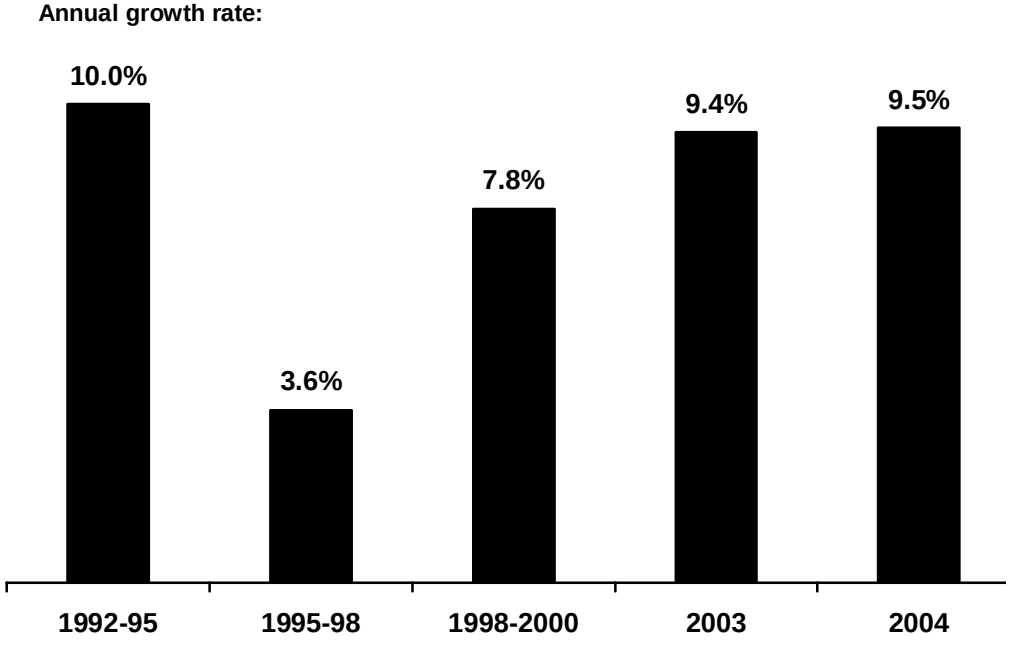
What are the trends in Medicaid expenditures?

In FY 2004, total Medicaid spending increased an average of 9.5%.[II] As Figure 4 shows, this increase is slightly more than 2003, but lower than the average annual growth rate of 11.9% that occurred over the 2000-2002 period.

State administrators cite several key factors as top drivers of Medicaid spending growth in FY 2004. The most frequently mentioned factors include:

- Medicaid enrollment growth
- Increasing costs of prescription drugs
- Rising costs of medical care
- Rising costs of long-term care

Figure 4: Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1992-2002: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64); For 2003 and 2004: Health Management Associates estimates based on information provided by state officials.

II. Total Medicaid spending reflects actual payments to medical providers for services rendered to beneficiaries. It includes special payments to providers, such as Disproportionate Share Hospital (DSH) payments but does not include Medicaid administrative costs. [see glossary for definition of DSH payments]

What are the trends in enrollment?

Medicaid enrollment increased during the economic downturn, as more families lost jobs and fell into poverty. Medicaid enrollment is projected to grow 4.7% in FY 2005, which is a slower pace than was seen between 2001 and 2004. State Medicaid officials attributed continued growth in enrollment to several factors:

- The economic downturn, resulting in increasing numbers of low-income uninsured people – particularly children and families (most significant for 23 states)
- The effect of eligibility expansions or restorations (10 states)
- Increased numbers of eligible elderly and disabled because of demographic changes (3 states)
- Outreach for programs such as the State Children's Health Insurance Program or food stamps, which identify additional persons eligible for Medicaid (3 states)

What is the current revenue picture?

Many individual states, including Michigan, are expecting large budget shortfalls for FY 2005 while Medicaid costs continue to increase.

Since 2001, as the national economy worsened and state revenues slowed, states have been forced to cut back on all state programs. As a result, they have had to make difficult choices that have affected health coverage for millions of low-income people across the country.

As states enter FY 2005, revenue has been growing and is expected to continue to grow; however, many individual states, including Michigan, are expecting large budget shortfalls for FY 2005 while Medicaid costs continue to increase. Additionally, the temporary fiscal relief to states provided by the federal government through the Jobs Growth and Tax Reconciliation Act of 2003 will end in 2005, thus significantly increasing the state share of Medicaid expenses. Anticipated gaps between revenue and expenditure growth will exert enormous pressures on states to reduce or control costs.

[**Michigan** officials cited overall caseload size and the phase out of special financing as key factors contributing to overall spending growth in FY 2004. For FY 2005, they cited increasing caseload, loss of one-time federal fiscal relief and loss of special financing as most significant factors.]

What strategies are states using to contain costs?

FY 2005 will be the fourth consecutive year that states have implemented significant cost containment initiatives, although a few states also are adopting modest benefit or eligibility expansions. Most states are implementing not just single cost containment measures but a more comprehensive set of strategies, including:

- Reducing or freezing provider payments
- Controlling pharmacy costs
- Reducing benefits
- Reducing or restricting eligibility
- Increasing co-payments
- Implementing disease management programs
- Implementing cost controls for long-term care
- Targeting fraud and abuse

Next, we will discuss how states are using each of these strategies.

Strategy 1: Reduce or freeze provider payments

Medicaid rates for payments to providers are generally the lowest of any payer, sometimes below the cost for delivering care. Payment reductions or freezes (which amount to reductions because of cost inflation) can have an impact on the availability of providers who will accept Medicaid and thus on access to care. Still, when faced with increasing fiscal pressures, many states used this strategy:

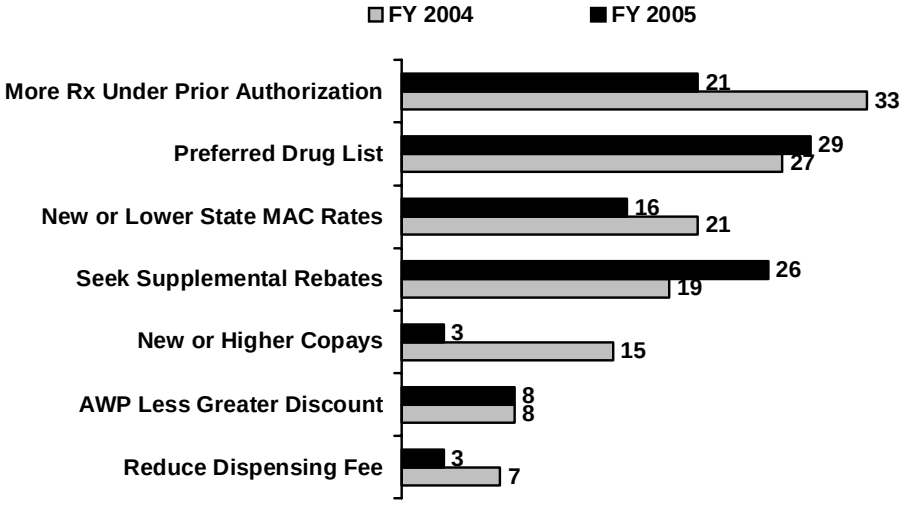
- In FY 2004, all 50 states and the District of Columbia cut or froze payment rates to at least one provider group; 47 states said they would so in FY 2005.
- States were most likely to cut reimbursement rates for physicians (42 states for 2004 and 33 for 2005).
- Cutting reimbursement rates to hospitals and nursing homes or Managed Care Organizations is more difficult because state statutes regulate reimbursement rates. Nevertheless, a number of states froze rates for one or more of these groups for 2004 or 2005.

[**Michigan** reduced or froze provider payments for FY 2004 and FY 2005.]

Strategy 2: Control pharmacy costs

States continued to focus significant attention on controlling the cost of prescription drugs, which have been growing at double-digit rates for several years. Cost containment strategies were implemented by 47 states and the District of Columbia in FY 2004 and by 43 states in FY 2005 (see Figure 5 drug cost reduction strategies).

Figure 5: Medicaid Prescription Drug Policy Changes FY 2004 and FY 2005



SOURCE: Kaiser Commission on Medicaid and the Uninsured survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004.

For 2005, the most frequently used strategies included:

- **Implementing preferred drug lists (29 states)**
- **Seeking supplemental rebates (26 states)**
- **Placing more drugs under prior authorization (21 states)**
- **Paying a larger discount off of the Average Wholesale Price (AWP) for drugs (8 states)**

In FY 2005, fewer states set lower Medicaid Maximum Allowable Costs (MACs)[III] for drugs (16 states) or reduced dispensing fees paid to pharmacies (3 states). For FY 2005 only 3 states or adopted new or higher patient co-payments; however, in FY 2004 15 states had done so, and Medicaid rules limit patient co-payments to a "nominal" amount – generally $3 per service. Thus, some states may have already reached the upper limit of co-payments.

[In FY 2004 **Michigan** implemented new or lower MACs, prior authorization for more drugs, and use of a preferred drug list; in FY 2005 Michigan implemented paying a larger discount off the AWP for drugs, a reduction in dispensing fees, and use of a preferred drug list.]

Strategy 3: Reduce Covered Benefits

In general, benefit cuts involved "optional" services, particularly those extended to adults, including elderly and disabled persons.

For FY 2005, fewer states were cutting benefits and more were restoring benefits cut in previous years:

- Only 9 states cut benefits in 2005, compared to 19 in 2004
- 14 states intended to restore or expand benefits cut in previous years

In general, benefit cuts involved "optional" services, particularly those extended to adults, including elderly and disabled persons. Services that were cut included:

- Dental, vision and hearing services for adults
- Chiropractic and podiatry services
- Psychological services
- Physical and occupational therapy
- Personal care services

Reducing eligibility for Medicaid is often difficult for states to implement because these reductions affect vulnerable populations who usually have no other access to health insurance.

States either eliminated these services entirely or limited the amount of services covered.

[**Michigan** suspended coverage in FY 2004 for adults for the following services: chiropractic, non-emergency dental, hearing aids, and podiatry. In FY 2005, it restored coverage for podiatry and hearing aids.]

Strategy 4: Reduce or Restrict Eligibility

Reducing eligibility for Medicaid is often difficult for states to implement because these reductions affect vulnerable populations who usually have no other access to health insurance. However, during the recent economic downturn, 38 states reduced or restricted Medicaid eligibility over a 4-year period (2002-2005). On the other hand, in 2004 and 2005 several states expanded coverage to previously excluded groups, such as the working disabled, people under family planning waivers, or uninsured women with breast or cervical cancers.

Eligibility changes fell into three categories: 1) eligibility rule changes; 2) application and renewal process changes; and 3) premium changes. We will discuss each separately.

III. State MAC programs assign upper limits to the amount Medicaid will pay for certain generic drugs for which the federal government has not set an upper limit.

Changes to Eligibility Standards

In order to receive the enhanced federal match authorized by the Jobs Growth and Reconciliation Act of 2003, states were required to maintain eligibility through June 2004 at the levels in effect on September 2, 2003. No states made reductions that affected the Medicaid matching rate in 2004. Although fewer states are implementing reductions in 2005, the changes will affect a larger number of people. States planned a variety of eligibility changes such as:

- Eliminating coverage for specific populations [e.g., medically needy adults with incomes above the TANF level] (2 states in FY 2004, 3 states in FY 2005)
- Eliminating continuous eligibility (2 states in 2004)
- Increasing the spend-down threshold level for the aged, blind, and disabled [amount of their own money they must spend before becoming eligible for Medicaid] (1 state in 2004)
- Reducing the income eligibility limit for certain groups [e.g, pregnant women with incomes between 200% and 235% of the federal poverty level; aged and disabled persons with incomes between 100% and 133% of the federal poverty level] (6 states in 2004; 3 states in 2005)

At the same time, some states expanded eligibility to previously uncovered groups by:

- Increasing the income eligibility level for aged and disabled individuals (1 state in 2004; 2 states in 2005)
- Eliminating TANF work requirements in determining eligibility for Medicaid (1 state in 2004)
- Enabling disabled workers to buy in to Medicaid coverage (2 states in 2004)

Changes to Application and Renewal Processes

Through the late 1990s and into 2001, states adopted measures designed to simplify and streamline Medicaid application and re-determination procedures. In the face of budget difficulties, some states reversed this process (10 states in 2004 and 4 in 2005). Major changes included:

- Instituting more frequent periods for re-verification of eligibility
- Eliminating continuous eligibility for certain groups (i.e., requiring periodic re-verification of eligibility)
- Eliminating policies that allow for self-declaration of income, in effect increasing the amount of required documentation

[**Michigan** made no reductions in eligibility in FYs 2004 or 2005. In 2004, it expanded coverage to disabled adults who are working through the Ticket to Work Program.]

Premium Changes

In a limited number of situations, states can require premiums as a condition of coverage. In 2004 and 2005 a few states implemented premium changes, including:

- Increased premiums for parents and children covered under expansion waivers (Massachusetts and Vermont)
- New or higher premiums for disabled workers (Iowa, Louisiana, Minnesota, and Nevada)
- New premiums on certain disabled children covered under the "Katie Beckett"[IV] rules (Maine)

IV. Rules that allow states to cover certain disabled children under 19 if the child meets SSI standards for disability, would be eligible for Medicaid if in an institution, and is receiving home medical care that would be provided in an institution.

[**Michigan** made no premium changes in FYs 2004 and 2005].

Strategy 5: Increase or Implement Co-payments

Payments must be "nominal" — generally defined as $3 or less per service.

When imposing patient co-payments, states must comply with the federal Medicaid law. Payments must be "nominal" — generally defined as $3 or less per service – and cannot apply to certain services, or certain eligibility groups, such as children or pregnant women. Over the past several years, states have relied more on co-payments as part of their cost containment strategies, although a substantial body of research indicates that even nominal co-payments can deter low-income individuals from receiving needed care.[3]

In FY 2004, 20 states imposed new or higher co-payments; for FY 2005, 9 states did so. The most frequent co-payment imposed was for prescription drugs (discussed under containing drug costs). A few states increased co-payments for:

- Hospital inpatient and outpatient visits
- Non-emergency use of emergency rooms
- Hearing, vision, dental and therapy services
- Physician office visits
- Ambulatory services
- Home health

[**Michigan** implemented no new or increased co-payments during 2004 or 2005.]

Strategy 6: Implement Disease and Case Management Programs

States have initiated programs to manage asthma, diabetes, hypertension, depression, congestive heart failure, mental and behavioral health, and obesity.

An increasing number of states are turning to disease and case management initiatives to help contain costs. Between 2002 and 2004, 42 states began programs. These initiatives are seen as a relatively low-cost way to improve health care for people with chronic and disabling conditions, including many adult Medicaid beneficiaries. Quality results from these programs are promising but not conclusive because there are several barriers: 1) participation is voluntary; 2) turnover is high among enrollees; and 3) payment rates to providers are low.[4] In a recent health benefits survey of employers,[5] 15 percent of firms responded that disease management strategies were very effective in containing costs.

The trend among states is clearly toward more comprehensive care management programs; states have initiated programs to manage asthma, diabetes, hypertension, depression, congestive heart failure, mental and behavioral health, and obesity. In the future, states may have a more difficult time implementing care management programs because persons eligible for both Medicaid and Medicare will be moving their drug coverage to Medicare.

[Michigan did not provide data on this strategy.]

Strategy 7: Implement Cost Controls on Long-Term Care and Home and Community Based Services

Although long-term care (LTC) represents over one-third of Medicaid spending, states did not initially adopt cost containment in this area. However, as other methods of controlling costs have been exhausted, states are beginning to focus on LTC. Cost containment strategies include:

- Reducing the number of nursing home beds
- Reducing the number of days for which Medicaid will pay a nursing home when the resident is in the hospital

- Reducing payments to nursing homes when a bed is held for a resident who is temporarily away from the facility for a number of days, e.g., visiting a child for a holiday
- Tightening eligibility criteria
- Downsizing the capacity of intermediate care facilities for the mentally retarded
- Changing formulas for nursing home reimbursement

In the past two years, some states have implemented cost controls on home and community-based services (HCBS), which are services provided to frail elderly and disabled persons in their own homes to prevent or delay their need for institutional care. Some states have limited the number of available Medicaid waiver slots for HCBS, thus reversing a trend of the past five years when states expanded access to community-based support services in response to the U.S. Supreme Court decision in Olmstead v L.C. (June, 1999). This decision found that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act.

Some states have limited the number of available Medicaid waiver slots for HCBS, thus reversing a trend of the past five years when states expanded access to community-based support services in response to the U.S. Supreme Court decision in Olmstead v L.C.

Other cost cutting measures in HCBS included:

- Limiting hours authorized for specific instrumental activities of daily living
- Restricting private duty nursing hours
- Reducing the allowable budget for high-cost cases
- Implementing utilization review procedures

[In FY 2004 **Michigan** implemented reductions to the Mediaid Personal Care Program (Home Help) by limiting the number of hours authorized for specific instrumental activities of daily living, freezing provider rates, limiting the definition of providers, and requiring annual recertification of medical need. For 2005 changes were made to definitions and screening procedures but these changes were expected to be revenue neutral.]

Strategy 8: Target Fraud and Abuse

Many states enhanced ongoing activities or started new activities designed to control fraud and abuse. In some cases these actions were tied to new management information systems, additional staff or an increased number of provider audits. Activities included locking high-use recipients in to a single doctor, establishment of a new fraud unit within the state Office of Inspector General, and a greater focus on third party liability recoveries. Between 2002 and 2005, 32 states have put in place new fraud and abuse mechanisms.

[**Michigan** implemented no new initiatives in fraud and abuse during this period.]

What are the issues for the near future?

As states moved into FY 2005 with a somewhat improved economic picture, several factors will present new challenges. We anticipate that three factors coming up in 2005 and 2006 will have in impact on states' ability to contain Medicaid spending growth.

Temporary federal relief that assisted states in 2003 and 2004 has come to an end, thus vastly increasing the state burden of Medicaid costs.

The Expiration of Federal Fiscal Relief

Temporary federal relief that assisted states in 2003 and 2004 has come to an end, thus vastly increasing the state burden of Medicaid costs. The Jobs Growth Tax Relief Reconciliation Act of 2003 provided states with an enhanced federal match rate (FMAP) for Medicaid expenditures. The enhanced FMAP enabled 36 states to resolve Medicaid shortfalls and helped 31 states avoid,

minimize, or postpone Medicaid cuts or freezes. With the expiration of the enhanced FMAP, state spending on Medicaid will grow enormously in FY 2005; legislatures have authorized spending growth in state general funds of 11.7% for FY 2005, compared to 4.8% growth in FY 2004. A number of state administrators commented on the fiscal hardship this will impose. However, officials in 20 states indicated that the expiration of the enhanced FMAP had been anticipated and the impact minimized.

Increased Scrutiny of Special Financing Arrangements

States that have relied heavily on these special financing arrangements report that the increased scrutiny will have a big impact on their state Medicaid financing.

As states have struggled in recent years to deal with Medicaid shortfalls without undermining essential services to vulnerable populations, some have turned to special financing arrangements to maximize the amount of federal money flowing to states. These arrangements include the use of funds from other governmental units (Intergovernmental Transfers, or IGTs) and/or provider taxes to make up the non-federal share of Disproportionate Share Hospital (DSH) payments[V] or Upper Payment Limit (UPL) reimbursements. At the same time, the federal Centers for Medicare and Medicaid Services (CMS) has increased its scrutiny of these arrangements, often through the Medicaid State Plan amendment approval process. States that have relied heavily on these special financing arrangements report that the increased scrutiny will have a big impact on their state Medicaid financing.

[**Michigan** officials cited increased scrutiny of special financing arrangements as a key factor driving Medicaid spending growth in the state.]

Implementation of the Medicare Prescription Drug Benefit

The greatest concern is about the "clawback" provision of the Medicare law that will require states to make payments to the federal government to help finance the drug benefit for those with dual eligibility.

Implementation of the new Medicare Part D drug benefit that is scheduled to take effect January 1, 2006 has provoked some concern among states regarding people who are eligible for both Medicare and Medicaid (dual eligibles).

- The greatest concern is about the "***clawback***" provision of the Medicare law that will require states to make payments to the federal government to help finance the drug benefit for those with dual eligibility.
- Proposed regulations raised the possibility that states may be responsible for enrolling in the Medicare Part D drug plan over 6 million individuals with dual eligibility. In addition, states were concerned that the Medicare drug plans will not cover all the medications now covered under Medicaid.
- States were also concerned that costs would increase because of a **"woodwork effect,"** as more Medicare beneficiaries discover they are eligible for Medicaid when they apply for the subsidies available to persons with low-incomes.

Only 3 states (California, New York, and Rhode Island) reported receiving additional administrative resources for FY 2005 to prepare for the implementation of the Part D Medicare benefit. However, all states will be expected to begin determining eligibility for Part D low-income subsidies beginning in July 2005 and must marshal the needed resources to accomplish this task.

V. DSH funds are provided to hospitals that serve a disproportionate share of uninsured patients.

What is the outlook for 2005 and beyond?

Medicaid did play a critical safety net role for many vulnerable individuals during the recent economic downturn. The current financing structure of the program, with federal matching dollars and guaranteed eligibility for those who qualify, allowed Medicaid to play this critical role. However, the challenges discussed above, combined with trends of increasing poverty and eroding private insurance, will continue to put pressure on Medicaid enrollment and spending growth. States are responding in different ways to these trends:

- Some states are seeking to control costs through Section 1115 waivers, which give them the flexibility to implement enrollment caps and benefit reductions.
- Several states have begun to view Medicaid as an effective means to address the issue of the uninsured and to expand coverage.

The recent period of fiscal stress has regenerated interest on the state and federal levels in restructuring the federal Medicaid law. Major issues include the way the program is financed and the relative role of states and the federal government. The direction this discussion takes will have significant implications for state budgets, for program beneficiaries, and for the ability of the program to serve as part of the safety net for vulnerable populations.

However, the challenges discussed above, combined with trends of increasing poverty and eroding private insurance, will continue to put pressure on Medicaid enrollment and spending growth.

For more detailed information on this survey, read the complete report: Smith, V., Ramesh, R., Gifford, K., Ellis, E., Rudowitz, R., & O'Malley, M. (2004, October). *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005.* Washington, DC: The Kaiser commission on Medicaid and the Uninsured. Available on line at www.kff.org/medicaid/7190.cfm.

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Family Caregivers: The Backbone of Long Term Care

Lynn Friss Feinberg, National Center on Caregiving

The Issue

Family caregiving has enormous economic value.

When we think of long-term care, we usually picture an elderly person in a nursing home; however, families provide the vast majority of support and direct care to frail elderly and persons with disabilities.[I] As Figure 1 shows:

- 78% of adults (18 and older) receiving long-term care rely **solely** on informal help, most often provided by family members (e.g., wives and adult daughters)
- 14% receive a combination of family care and paid assistance
- Only 8% rely exclusively on formal care.[1]

Family caregiving has enormous economic value (see Figure 2):

- With an estimated value of $257 billion nationally (2000 dollars), it surpasses costs of home health care ($32 billion) and nursing home care ($92 billion) combined.[2]

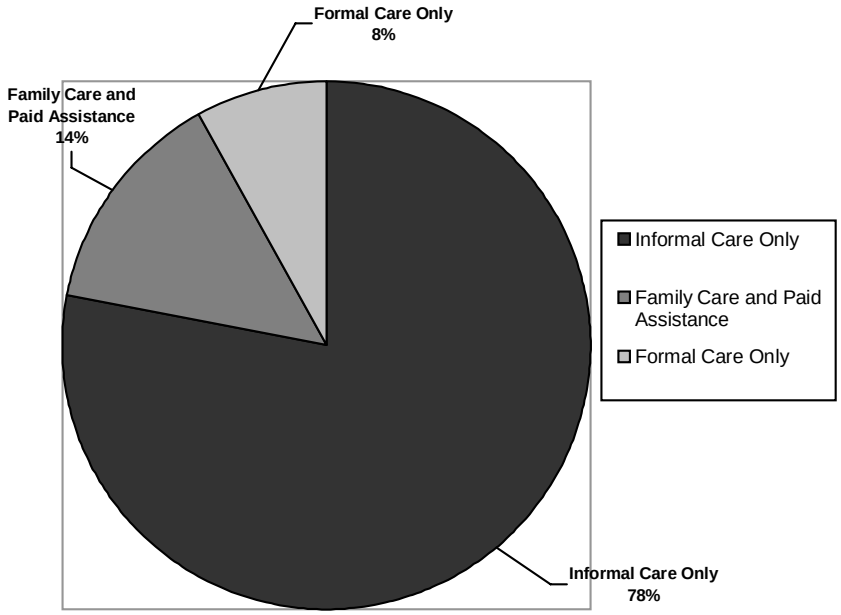
Federal and state policymakers are now recognizing the important role family caregivers play in easing the burden on the more expensive formal long-term care system.

Until recently public policy has neither acknowledged nor supported service needs of family members in their caregiving role. However, federal and state policymakers are now recognizing the important role family caregivers play in easing the burden on the more expensive formal long-term care system. Indeed, the availability of family and informal caregivers is often the deciding factor in determining whether an individual can remain at home or must turn to more costly nursing home care.[3]

Although the federal government has increased its role in financing caregiver support for older people through the National Family Caregiver Support Program (NFCSP), states still lead the effort in effort in recognizing and supporting the family caregiver. Because little was known about the experiences of states in providing caregiver support, the Family Caregiver Alliance, with funding from the U.S. Department of Health and Human Services Administration on Aging, undertook two studies to learn more about how states are implementing caregiver support.[4 5 6] This report is a brief summary of findings from those and other studies of state initiatives [Feinberg, Hunt, et al., 2004].

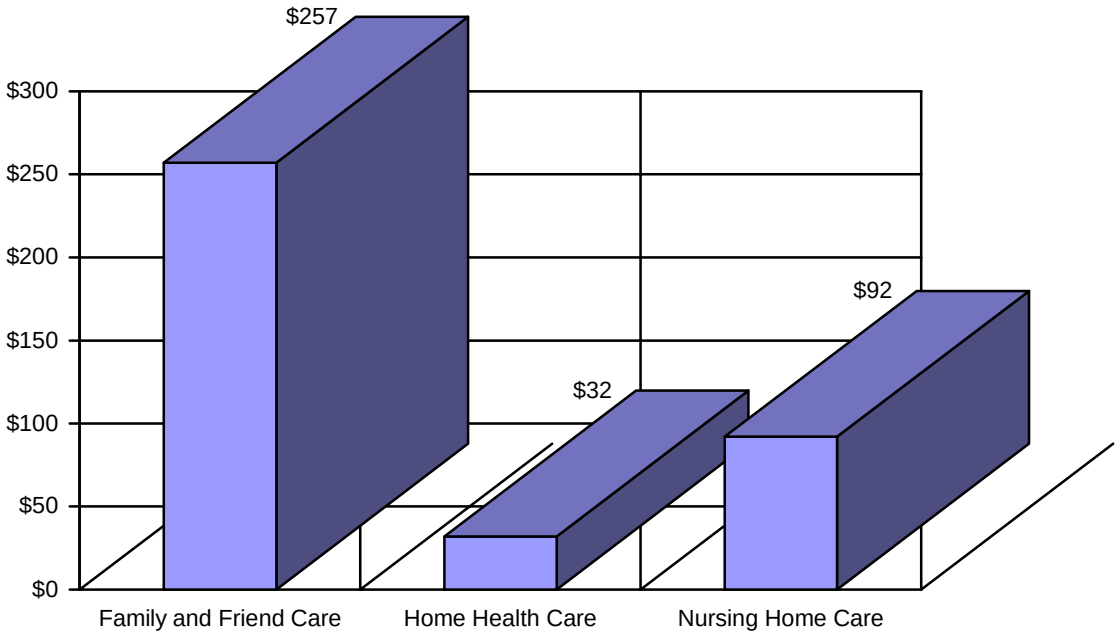
I. Informal care is provided by a family member, friend or volunteer and consists of assistance with a range of activities, including hands-on help with personal care needs; running errands or assisting with transportation; helping to educate the consumer about their health and long-term care needs; arranging and/or providing financial assistance for health and long-term care needs such as medications, doctor visits, and formal care. Formal care consists of assistance from paid providers, often paraprofessionals such as personal assistants or home care aides; this care can be provided in-home or in a facility such as an adult day care center.

Figure 1: Type of Care Received



Source: Thompson, L. (2004. March). *Long-term care: Support for family caregivers* (Issue Brief). Washington, DC: Georgetown University, Long-term Care Financing Project.

Figure 2: Value of Family Caregiving



Source: Arno, P.S (February 2002). "The Economic Value of Informal Caregiving," updated figures presented at the American Association for Geriatric Psychiatry meeting, Orlando, FL

What Strategies Are States Using to Support Family Caregivers?

Family caregiver support programs are part of a larger configuration of services, known as home and community-based services (HCBS), whose goal is to maintain frail elderly and disabled persons in their own homes as an alternative to institutional placement.

Family caregiver support programs are part of a larger configuration of services, known as home and community-based services (HCBS), whose goal is to maintain frail elderly and disabled persons in their own homes as an alternative to institutional placement. Most services are targeted directly toward the elderly or disabled person; family caregiver services are one component of this system of HCBS. In general, these programs are administered by the local Area Agencies on Aging (AAAs).

States are using four main approaches to caregiver support:

- Enhanced Direct Services
- Consumer-Directed Options and Financial Compensation
- Tax Incentives
- Workplace and Family Leave Policies

[For a summary of Michigan programs, see chapter 3 page 26.]

Strategy 1: Bolster direct services

Most states face a difficult balancing act between sufficient flexibility to encourage individualized options and the need to set statewide standards.

States vary widely in how services are organized and integrated into service systems. Two states (California and Pennsylvania) have comprehensive programs that were started using state general funds. Most states face a difficult balancing act between giving local Area Agencies on Aging (AAAs) sufficient flexibility to encourage individualized options and the need to set statewide standards for uniformity of core services. In the majority of states, caregivers in different parts of the state cannot access the same package of services.

The following services are offered by most states:

- **Respite care** (temporary alternative care) is the service most typically funded by states. The definition of "respite" and eligibility criteria vary widely across states; the number of available services varies within states. [In **Michigan**, respite care is offered through state- and federally-funded programs; adult day services and in-home care are available.]
- **Supplemental services** (e.g., assistive devices, consumable supplies, home modifications) are seen as another high priority need of family caregivers. [**Michigan** funds some supplemental services through its two programs receiving federal funds, MI Choice and the Family Caregiver Support Program].

How are states funding expanded services?

States are using federal and state funding streams to support family caregivers.

States are using federal and state funding streams to support family caregivers. Major sources include:

- **The National Family Caregiver Support Program (NFCSP).** This federal program was authorized by the Older Americans Act of 2000 to support the important role that family caregivers play by offering states the opportunity to provide for caregiver needs directly. It allocates formula grants to states based on population and in FY 2005 $163 million (including $6 million for Native American caregivers) was allocated to the program – a $4 million increase over the prior year. While there are no income eligibility requirements for the NFCSP, states are required to give priority consideration to persons in greatest social and economic need, with

particular attention to low-income, minority individuals. The NFCSP allows states to provide to family caregivers:

- Information to about available services
- Assistance in gaining access to supportive services
- Individual counseling, support groups, and training
- Respite care to temporarily relieve caregivers
- Supplemental services on a limited basis to complement family care

- **Home and Community Based Medicaid Waivers [MI Choice in Michigan].** These waivers allow states to provide certain home-based services to low-income persons who otherwise would be eligible for institutional care. Services provided under Medicaid waivers must be directed toward the recipient rather than the family system. However, waivers allow states to offer support indirectly to family caregivers by:
  - Paying for respite care
  - Purchasing supplementary services, such as home modifications, education, and training
  - Expanding eligibility to include individuals with incomes up to 300% of standard Medicaid eligibility [In Michigan individuals with disabilities are eligible for Medicaid if they receive Supplemental Security Income; elderly persons are eligible if their income is more than 100% of the Federal Poverty Level]

Home and Community Based Medicaid Waivers allow states to provide certain home-based services to low-income persons who otherwise would be eligible for institutional care.

- **Tobacco settlement money**. Several states[II] are using portions of their tobacco settlement funds in programs for family caregivers. [Michigan funds a caregiver respite program with tobacco settlement funds].

- **State general funds**. The NFCSP requires a 25% match, which states generally meet using some combination of state general funds, local funds and in-kind contributions.[III] In addition, states such as California, Pennsylvania and Washington commit significant state general funds for explicit caregiver support programs providing a range of services (e.g., caregiver assessment, family education and training, individual/family counseling, respite care and/or cash grants or reimbursements for services) to family caregivers in their state. [Michigan uses Blue Cross/Blue Shield Escheat funds to support respite care.]

Strategy 2: Promote Consumer Direction and Direct Financial Compensation to Caregivers

"Consumer direction" describes a range of approaches that offer choice and control for people who use services to help with daily living. These programs offer families maximum control of how, when, and by whom respite is provided and/or give families the option of purchasing goods or services directly, rather than receiving them through an agency providing the services. Popular consumer-directed options include:

"Consumer direction" describes a range of approaches that offer choice and control for people who use services to help with daily living.

- Vouchers that family and informal caregivers can use to purchase supplemental services
- A variety of respite service options
- Direct payments to family caregivers

II. Florida, Georgia, Iowa, Michigan, Nebraska, Nevada, Pennsylvania
III. A state may use other funds currently used for related programs to match the federal NFCSP so long as such monies are not from other federal sources, e.g., Medicaid, and are not used to match other programs.

States vary widely in the extent to which family caregivers have consumer-directed options:

- **Illinois** allows AAAs to offer vouchers (averaging $1,000 per year) to family caregivers for goods or services ranging from home modifications to lawn care.
- **Georgia** is involved in a demonstration project to develop self-directed care projects for elderly in rural areas who are not eligible for Medicaid.
- **North Dakota** is addressing a **shortage of direct-care workers in rural areas** by allowing payments of up to $700 per month to eligible spouses or other family members who provide care to individuals who might otherwise be eligible for nursing home admission. Costs are far less than the estimated $3,200 per month for nursing home care.
- **Arkansas, Florida, and New Jersey** initiated a program called **Cash and Counseling**, which pays cash allowances, coupled with information services, directly to consumers to purchase services. Begun as a demonstration project funded by the Robert Wood Johnson Foundation and the U.S. Dept of Health and Human Services, it has expanded to 10 states because of early success.[7] [Michigan has a Cash and Counseling program that was initiated in 2004.]
- **Michigan** has a voucher program and allows consumer choice in respite options.

Arkansas, Florida, and New Jersey initiated a program called Cash and Counseling, which pays cash allowances, coupled with information services, directly to consumers to purchase services.

Strategy 3: Expand Tax Incentives

State tax incentives include tax credits and tax deductions. Twenty-six states and the District of Columbia offer state income tax deductions for expenses, usually up to $2,400, or tax credits of $500 to $1,000. **Tax credits** are the most popular option because they generally benefit lower-income taxpayers and are often viewed as a more equitable way of providing tax incentives. [Michigan has no state tax deductions or tax credits for caregiver services.]

Strategy 4: Expand Workplace and Family & Medical Leave Policies

For workers in businesses with more than 50 employees, the federal Family and Medical Leave Act of 1993 (FMLA) guaranteed 12 weeks of unpaid leave to care for a new child or ill family member without risking their job. By expanding FMLA, states can help caregivers balance work and family roles. However, since the duration of caregiving averages 4.3 years and for Alzheimer's patients can last up to 20 years, the amount of leave allowed by FMLA falls short of addressing the realities that many caregivers face.

States have expanded the scope of the federal FMLA in several ways:

- Allowing leave in workplaces with less than 50 employees (Oregon, Vermont)
- Expanding the range of needs that fall under the law (Maine, Massachusetts, and Vermont)
- Expanding the definition of "family" (Hawaii, Oregon, Rhode Island, Vermont)
- Extending leave periods (California, Connecticut, Louisiana, Oregon, Rhode Island, Tennessee)
- Offering paid leave (California)

The **California leave program**, which began offering benefits July 1, 2004, is the most comprehensive in the nation. It has the following provisions:

- Provides up to six weeks of paid leave each year by expanding the state disability insurance program to allow workers to care for an ill child, spouse, parent or domestic partner
- Replaces workers' wages at the level of 55-60% of wage, up to $728 per week
- Is 100% funded by an employee tax at an average cost of $27 per year per worker

[At this time, Michigan has not expanded upon the federal minimum under the FMLA.]

Key Findings from the 50-state Survey of Family Caregiver Support Programs

A recent survey of programs in all 50 states[5] illuminated the large role that states play in support of family caregivers of frail elderly and persons with disabilities. Key findings of the survey are discussed below.

- **Publicly funded services are increasing, but access is uneven within and across states**

  State administrators identified a lack of adequate resources to meet the range of caregiver needs as the top unmet need. This lack leads to gaps in services and limited options for some, depending on where they live.

- **NFCSP is emerging as a key program to enhance the scope of services, but is inadequately funded**

  Compared to Medicaid and other Home and Community Based Services (HBCSs), the current funding level for the NFCSP is too low to support the multifaceted needs of all family caregivers. However, it does fill a gap by providing some support to low- to moderate-income families who are not eligible for Medicaid.

- **Broad recognition of the value of uniform caregiver assessment exists; however, approaches vary greatly.**

  Good assessment of needs is crucial to maintaining quality services. Although a few states uniformly assess what caregivers need to sustain caregiving, the majority of state-funded and Medicaid waiver programs assess only the recipient of services. Systematic assessment of caregiver needs is central to improving policy and practice in HCBS.

- **States have different perspectives on approaches to system development, the importance of caregiver services within home and community-based care, and integration of family caregiving programs into HCBS.**

  Recognizing family caregivers as legitimate "consumers" is a new concept for states,[4] and administrators lacked agreement about how and to what extent service integration with other support programs for elderly and disabled persons should take place.

Because our current HCBS system relies heavily on family and informal caregivers, families will need more help as they struggle to balance competing demands of work, family and caregiving. A family-centered rather than client-centered approach to assessment and services should be considered as states pursue the goal of strengthening integrated systems of home and community-based care.

What Can States Do to Promote Caregiver Support?

Recommendation 1: Pursue federal Systems Change Grants to promote a "family systems approach" to HCBS.

In January 2001 the Centers for Medicare and Medicaid Services (CMS) announced a new grant program for Real Choice Systems Change grants to help states improve community long-term support systems for people with disabilities and their families. These grants present opportunities for aging, disability, and family advocates to shape state policy to strengthen caregiver supports.

[In 2001, the **Michigan Department of Community Health** was awarded a 3-year Real Choice Systems Change grant by CMS. The goals of the grant were to develop quality indicators across all long-term care settings; include consumers on HCBS site monitoring teams; develop web-based options to determine eligibility and to obtain and manage services; and develop models for consumers' and families' collective control of resources for community living. In 2001, Michigan was also awarded a Nursing Family Transitions grant and a Community Integrated Personal Assistance Services and Support grant under the Systems Change program.]

Recommendation 2: Adopt a uniform assessment of caregiver needs in all HCBS programs in the state that provide caregiver support, and advocate for uniform national assessment standards.

Presently, only five states using a uniform assessment tool include assessment of caregiver needs (not including Michigan). Identifying and meeting the needs of family caregivers is often the deciding factor in whether an individual can remain in the home, so understanding and addressing caregiver needs is critical to keeping individuals out of more expensive institutional care.

Recommendation 3: Advocate for improved, uniform data collection and reporting standards in the NFCSP and other caregiver support programs.

Accountability is key to success of the NFCSP and other caregiver support programs. However, state program administrators currently use a range of definitions and data collection methods to track expenditures, service delivery and outcomes. Uniform reporting will provide better data, which supports better decision-making and higher quality of care. Without uniform data across all programs, it is not possible to assess the quality or outcome of services.

Recommendation 4: Conduct a statewide public awareness campaign on family caregiving or participate in national campaigns.

The recent 50-state survey found that recurring themes were lack of public awareness about caregiver issues and the notion that caregivers do not self-identify with the term "caregiver." Outreach to informal caregivers specifically, and to the public in general, is crucial to ensuring that families and friends have access to information and support services early in the caregiving process.

Recommendation 5: Invest in staff training and technical assistance.

States want to learn from the successes and challenges experienced by other states. Over 90% of survey respondents identified 5 training topics as most likely to benefit staff: 1) best practices in service delivery; 2) culturally/ethnically appropriate services; 3) program evaluation/outcome measures; 4) outreach/public awareness; and 5) caregiver assessment. State administrators expressed an interest in program design to provide a broader array of services, develop greater consumer direction and choice, and use technology to access hard-to-reach caregivers.

States can take a range of approaches to training and technical assistance. States can use federal funds from the aforementioned Real Choices grant program to develop uniform assessment instruments that include a caregiver component; implement program evaluation/outcome measures for use in programs across their state's HCBS system; and establish single points of entry. NFCSP funds could be used in a range of areas, including developing marketing and other materials to facilitate outreach and public awareness; develop best practices; and focus on delivering culturally/ethnically appropriate services. Policymakers and program administrators can build on successful models used in other states.

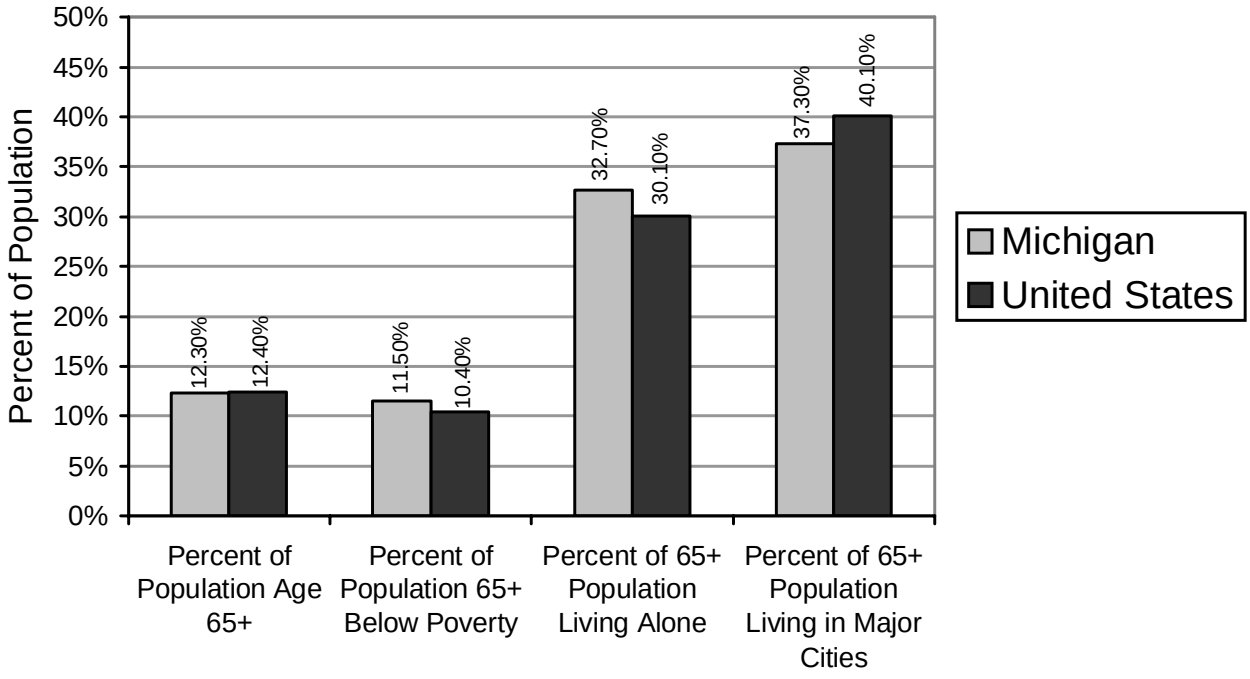
Michigan Programs to Support Family Caregivers

Laura Bates

What does Michigan's elderly population look like?

Michigan has 1,290,000 individuals 65 years of age or older, representing 12.3% of the population; individuals 85 years of age and over represent about 1.4% of the population.[1] These Michigan figures are similar to national figures. However, as shown in Figure 1, a larger proportion of Michigan seniors live below the poverty line or live alone. Only 37.3% live in major cities, and getting services to homebound people in rural areas can be a major challenge. In addition, Michigan has a number of elderly individuals who are caring for their grandchildren, as approximately 3.1% of children live with a grandparent who is 65 years of age or older. All of these factors indicate a potentially large need for caregiver support services.

Demographics for Persons Age 65 and Over



Data Source: *The State of the States in Family Caregiver Support: A 50-State Study. State Profile: Michigan.* San Francisco, CA: Family Caregiver Alliance (November, 2004). Available online at http://www.caregiver.org/caregiver/jsp/home.jsp

Family Caregivers

Michigan has approximately one million informal (family & friends) caregivers who perform over 1 billion hours of caregiving annually.[2] Their unreimbursed services have a value of more than $9 billion.

How does Michigan support family caregivers?

Michigan has four programs, totaling more than $22 million, that provide some level of support to family caregivers. The largest program, MI Choice, is a Medicaid home and community-based waiver program administered by the Michigan Department of Community Health. One other federal and two state funded programs are administered by the Michigan Office of Services to the Aging (OSA) at the state level and by the 16 Area Agencies on Aging (AAAs) at the local level. Because requirements and funding streams differ, we will discuss each program separately.

Federal and State Funded: MI Choice Medicaid Waiver Program

MI Choice is Michigan's 1915 (c) Medicaid waiver program, providing an alternative to nursing home care.

MI Choice is Michigan's 1915 (c) Medicaid waiver program, providing an alternative to nursing home care. Funded by state and matching federal Medicaid dollars, this program provides low-income elderly and disabled individuals with Medicaid-covered services comparable to those provided in nursing homes but within the person's own home. Services must be directed toward the recipient; however, several services, particularly **respite** care, benefit the caregiver as well. The waiver serves approximately 8,000 elderly and disabled individuals a year.[3] For respite care, the service that most directly benefits family caregivers, the total expenditure in FY 2002 was $10,063,820.[4]

Who may receive MI Choice services?

Eligible persons must be 18 or older with a disability, or elderly (65 years or older) with an income that is no more than 300% of the eligibility level for adults receiving Medicaid.

Eligible persons must be 18 or older with a disability, or elderly (65 years or older) with an income that is no more than 300% of the eligibility level for adults receiving Medicaid, which is 100% of the Federal Poverty Level or eligibility for Supplemental Security Income.[5] Currently in Michigan, the income eligibility level is $1692/month for an individual.[6]

What services are offered?

MI Choice services are targeted to the aged or disabled individuals rather than the caregiver. Covered services include:

- Respite in-home care and adult day care
- Homemaker services
- Personal care
- Chore Services
- Private duty nursing
- Environmental modifications
- Personal Emergency Response systems
- Transportation
- Medical supplies and equipment
- Home-delivered meals
- Counseling
- Training in independent living skills

- Nursing facility transition services for nursing home residents to assist them in transitioning to a community-based setting

Respite services, which allow for out of home respite up to 30 days per year, medical supplies and equipment, and counseling can also benefit the family caregiver. However, MI Choice will not pay family members to provide homemaker or chore services or personal care.

How are service needs determined?

Generally, the person applying for services receives a visit from a nurse/social worker team from the agency who assess the client's needs. A Cash and Counseling program offers additional consumer choice in services and service providers.

What is Cash and Counseling?

The program offers greater consumer choice by issuing vouchers for services within an agreed-upon plan of services and allows the consumer to determine who will provide these services.

Funded by the Robert Wood Johnson Foundation in addition to Medicaid and local funds, this pilot program is targeting 600 consumers in the MI Choice program at three pilot sites. The program offers greater consumer choice by issuing vouchers for services within an agreed-upon plan of services and allows the consumer to determine who will provide these services. The managing agency offers education and counseling about service options and providers of services.

For more information about Cash and Counseling contact: Michael Head, Director, Office of Consumer-Directed Home and Community-Based Services, Michigan Department of Community Health. Phone: (517) 335-0276; e-mail: head@michigan.gov.

Where can one find out about MI Choice services?

MI Choice services are provided through waiver providers around the state. Many are AAAs; others are health or human service agencies. More information about agencies that administer MI Choice services can be found on the Web at: http://www.michigan.gov/mdch/0,1607,7-132-2943_4857_5045-16263—,00.html.

Federally Funded with State Match: Family Caregiver Support Program

The federal National Family Caregiver Support Program provides funds that are allocated to Area Agencies on Aging (AAAs) for services to family caregivers.

The federal National Family Caregiver Support Program (U.S. Department of Health and Human Services/Administration on Aging, Michigan Office of Services to the Aging) provides funds that are allocated to Area Agencies on Aging (AAAs) for services to family caregivers. It also underwrites some kinship care services (services to grandparents raising grandchildren). In FY 2003, program expenditures in Michigan were $4,727,473.[7]

Who is eligible?

Services are offered to caregivers of individuals 60 or older or caregivers themselves who are 60 or older and are caring for someone who needs assistance with two or more activities of daily living or has a cognitive impairment and has limited ability to care for him- or herself. In order to be eligible for kinship care services, a grandparent must be 60 years or older and caring for a grandchild who is 17 years of age or younger. States are required to serve those with greatest social and economic need, although there are no income requirements.

What services are offered?

The program funds a number of services for caregivers, including:

- Information
- Assistance
- Counseling/Support Groups/Training

- Respite services (adult day services, in-home care, overnight or weekend)
- Supplemental services (e.g., transportation, consumable supplies)

Families **cannot** be paid to provide care.

Do consumers have a choice in services?

Some regions allow for the use of vouchers for respite and consumable supplies. Families have a choice of respite providers.

Where can one get more information?

The program is administered through local AAAs.

State-funded: Escheat Respite Program

The State Escheat[1] Respite Program was created by Michigan Legislative mandate through Public Act 171 of 1990. The State Escheat Fund, administered by OSA, is allocated to each of the 16 AAAs based on a formula. In FY 2003, expenditures were $2,442,565.[8]

Who is eligible for services?

Caregivers who are 60 year or older, or caregivers of individuals who are 60 years or older can receive services. State statute requires agencies to serve those with greatest social and economic need, although there are no income requirements.

What services are provided?

The State Escheat Program funds only respite services. This includes adult day care or in-home care.

Where can one get more information?

The program is administered through local AAAs.

The State Escheat Program funds only respite services. This includes adult day care or in-home care.

State-Funded: Tobacco Settlement Caregiver Respite Program

This program is funded with Tobacco Settlement money through the AAAs and Non-AAA's based on formula. FY 2003 expenditures were $4,972,401.[9]

Who is eligible?

Caregivers of individuals over 18 years of age with a medical disability are eligible. For persons 60 years of age or older, there is no functional status requirement. State statute requires agencies to serve those with greatest social and economic need, although there are no income requirements.

What services are offered?

This program pays for respite services, including in-home care, adult day care and transportation.

Where can individuals apply for services?

Many of these services are administered through the local AAAs. In addition, certain other providers of Medicaid Waiver services also provide respite services through this program.

This program pays for respite services, including in-home care, adult day care and transportation.

1. Escheat refers to unclaimed reimbursements or payments made by Blue Cross/Blue Shield of Michigan that revert back to the state and are set aside for health-related programs.

Do home and community-based services save money?

The State of Pennsylvania is conducting a cost analysis to determine whether home and community-based care is still less expensive when the woodwork effect is taken into account.

Nationally, the average cost of home-based services for an individual is $485 per month, compared to $2426 per month for nursing home care. [In [**Michigan**] the average monthly Medicaid expenditure for nursing home care is over $3200].[10] Thus, the per capita expenditure is definitely less, but to assess the total cost, one must take into account the additional demand that offering this service may generate. Some people who would not accept nursing home services, would sign up for services in their own home, creating a **"woodwork effect"** of increased demand for services.

The State of Pennsylvania is conducting a cost analysis to determine whether home and community-based care is still less expensive when the woodwork effect is taken into account. Data from this study was not available at the time of this printing.

For more information contact: Dan McGuire, Director, Bureau of Home and Community-Based Services, Pennsylvania Department of Aging, Forum Place 555 Walnut Street, Harrisburg, PA., dmcguire@state.pa.us

Dr. Nigel Paneth is a pediatrician and perinatal and child health epidemiologist whose particular interest is in the causes and prevention of childhood neurodevelopmental handicaps, such as cerebral palsy. Dr. Paneth has conducted a number of major studies whose aim is to understand the factors effecting brain damage in newborn infants has investigated the effect of level of care on low birth weight infants. He is a professor of pediatrics and human development, professor of epidemiology. As associate dean for research in the College of Human Medicine at Michigan State University, he has been a supporter of the work of the MSU Obesity Council. He is a graduate of the Harvard Medical School and has a Master's in Public Health from Columbia University School of Public Health.

Preventing Childhood Obesity

Nigel Paneth, Michigan State University

Health care costs for obesity in the United States are nearly $120 billion annually, or about 7% of total health care costs. ***One half of all obesity health care costs are underwritten by Medicaid and Medicare. This reflects what is being called the obesity epidemic.*** *Except for post-famine periods, the United States has probably experienced, in the past two decades, the largest across the board weight gain in human history!*

One half of all obesity health care costs are underwritten by Medicaid and Medicare. This reflects what is being called the obesity epidemic.

Any discussion of controlling Medicaid costs in Michigan must consider this epidemic of obesity and ways of dealing with it, inasmuch as Michigan has a higher than average proportion of obese and overweight adults and children.

The Increase in Obesity and Overweight in Adults and Children

- Over a period of 30 years, the prevalence of **obesity among adults** in the United States has increased substantially. Obesity in adults is defined as a body mass index of more than 30, which corresponds to being about 30 pounds over ideal weight for the average woman and about 40 pounds over ideal weight for a man.
- In 1985 a random sampling of adults who were asked their heights and weights found no states with as many as 15% of respondents obese; in 2/3 of states studied less than 10% of the population were obese. In 2002, just 17 years later, no states remained in which less than 15% of the population was obese. In most states more than 20% of the population is obese, and in 3 states more than 25% of people are obese.
- Similar increases in prevalence of overweight have occurred among **children and adolescents.** Overweight for children and for adolescents is considered to be more than 95 percentile body mass index for age.
- The percent of overweight children age 2-5 doubled from 5 to 10% in the 26 years from 1971-74 to 1999-2000.
- The percent of overweight children age 6-11 increased almost 4 times, from 4 to 15%, in the same time period
- The percent of overweight adolescents more than doubled from 5 to 11%, in the same time period.
- The percent of obese and overweight persons in Michigan has been trending upward since 1987: 45% in 1987 71% in 2000.

The percent of overweight children age 2-5 doubled from 5 to 10% in the 26 years from 1971-74 to 1999-2000.

What's Wrong with Obesity?

Obesity is associated with substantial increases in risks for chronic diseases, chronic disability, higher medical expenditures as previously noted, decreased productivity, and death.

- Increase in risks for chronic diseases:
  - 10 times increase in diabetes
  - 3-10 times increase in osteoarthritis
  - 2-3 times increase in cardiovascular disease
  - 50% increase in cancer deaths
  - Health care costs: Obesity health care costs account for about 1% of the gross domestic product.
  - Diminished productivity: Persons who are obese experience
  - 50-90% increase in sick leave
  - 1.5 -2.2 times increase in disability

What Causes Obesity?

Obesity is caused by an excess of "calories in" over "calories out."

An individual's weight is nothing more than the balance between calories ingested and absorbed, and calories expended. **Obesity is caused by an excess of "calories in" over "calories out."**

Do We Know How to Prevent Obesity?

Interventions can be at the community level (ecological interventions) or at the individual level.

Individual level interventions

At the individual level, through the health care system, we can promote awareness of the benefits, and adoption of, good diet and exercise. However, there is limited high quality data on the effectiveness of obesity prevention programs and no generalizable conclusions can be drawn. There is a lack of good quality evidence on the effectiveness of interventions on which to base national strategies or to inform clinical practice.

- "Evidence is insufficient to recommend for or against routine screening for overweight in children and adolescents as a means to prevent adverse health outcomes."[1]

Over the history of preventive efforts in other arenas, community level interventions, such as water chlorination, have been found to be more efficient than interventions directed at individuals.

Community Level Interventions

Over the history of preventive efforts in other arenas, community level interventions, such as water chlorination, have been found to be more efficient than interventions directed at individuals. **Community level interventions can be initiated by legislative action** that changes policy or provides funding.

Evaluation

We must take a critical look at programs to prevent obesity and evaluate their effectiveness. We cannot take effectiveness for granted.

A wide variety of community programs combining diet and exercise are now being studied – the GEMS program targeting African-American girls ages 8-10 in five cities; The Hip-Hop program for toddlers in head start programs; the Go Girls program for adolescents in Atlanta. However, we do not yet know how effective these programs are.

What community level policies can we adopt that might decrease the energy intake of children ("calories in")?

- Change school lunch contents
- Change contents of vending machines in schools

What community level policies can we adopt that increase the expenditure of energy by adults and children ("calories out")?

- We can modify municipal and state policies and planning around the built environment to encourage walking, running, biking, outdoor activity
- When roads and streets are built or repaired, include designated bike lanes whenever possible
- Require new residential areas to have sidewalks
- Convert abandoned railroad beds to walking/biking trails
- Provide safe approaches for pedestrians and cyclists at shopping malls
- Reduce urban sprawl; promote neighborhoods with schools and other facilities within walking distance
- We can encourage children to walk or bike to school
- We can go back to requiring physical education in the schools

We can provide community-wide education on the basis of its "effectiveness in increasing physical activity and improving physical fitness among adults and children."[2] Encouraging exercise may be easier to achieve than reducing caloric intake.

What Should Legislators and Policymakers Know?

1. Recognize that we are in the midst of an epidemic that is still growing
2. Recognize that we do not yet know exactly what we should do to prevent obesity – there is no magic bullet
3. Recognize that some determinants of energy balance can be influenced by legislators and policy makers

What should Legislators and Policymakers Do?

1. Encourage a variety of community approaches that simultaneously address calories in and calories out. Encouraging exercise may be easier than changing diet.
2. Evaluate the interventions carefully, so we sort out what works from what doesn't.

Policies and Programs to Promote Healthy Lifestyles Among Michigan's Children

Bethany Anne Zimmerman

Why do we need to promote healthy lifestyles in Michigan?

The prevalence of overweight and obesity among adults in the United States has increased significantly in recent years. The rate of overweight among children and adolescents has similarly increased. The annual health care costs for obesity are almost $120 billion nationwide. Medicaid and Medicare underwrite half of the health care costs for obesity.[1]

Obesity is associated with a considerable increase in risk for chronic diseases. The risk for developing diabetes is increased 10 times, and the risk for developing cardiovascular disease is increased 2-3 times.

- Michigan has a higher than average proportion of overweight and obese children and adults.[2]
- In 2000, 61% of persons in Michigan were overweight or obese (39% overweight and 22% obese).[3]

Obesity is associated with a considerable increase in risk for chronic diseases. The risk for developing diabetes is increased 10 times, and the risk for developing cardiovascular disease is increased 2-3 times.[4]

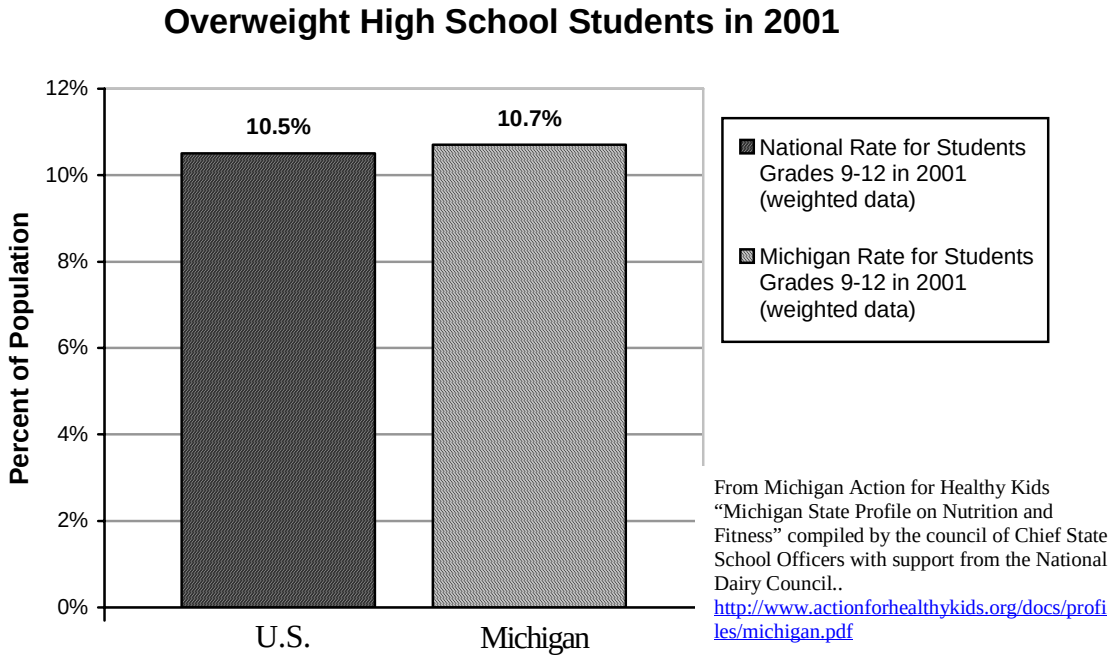
- Heart disease is the leading cause of all deaths in Michigan and the nation, as well as the leading cause of premature death for black males statewide.[5]
- Children and youth are showing increasing rates of risk factors associated with heart disease. This will contribute to increasing rates of heart disease in the future.[6]
- The costs of all heart disease in Michigan for 2003 were estimated at $8.07 billion.[7]
- Michigan rates of heart disease mortality are consistently higher than the national average.[8]

Diabetes, as an underlying cause, is the sixth leading cause of all deaths in Michigan and the tenth leading cause of years of potential life lost (YPLL) for people under 75 years old.

Diabetes is a chronic disease associated with increased risk for heart attack, blindness, birth defects, amputation, and kidney failure.[9]

- Diabetes, as an underlying cause, is the sixth leading cause of all deaths in Michigan and the tenth leading cause of years of potential life lost (YPLL) for people under 75 years old.[10]
- In the past six years there has been a 24% increase in the rate of persons clinically diagnosed with the disease in Michigan.[11]
- The increase in diabetes prevalence has been higher in Michigan than for other states.[12]
- Diabetes-related medical costs in Michigan exceed $2.9 billion annually with 60% of the costs attributed to hospitalization.[13]

How many of Michigan's children are overweight?



From Michigan Action for Healthy Kids "Michigan State Profile on Nutrition and Fitness" compiled by the council of Chief State School Officers with support from the National Dairy Council..
http://www.actionforhealthykids.org/docs/profiles/michigan.pdf

1. The rate of overweight for Michigan high school students is slightly higher than that of the nation.
2. In 2001 10.7% of Michigan students in grades 9-12 were overweight compared to 10.5% of 9-12 graders nationwide

What can we do to reduce the risks?

As stated in Healthy Michigan 2010, "the goal of chronic disease prevention and control efforts is to improve the health of all of Michigan's populations through preventing chronic diseases or delaying their onset until very late in life through:

- Increased physical activity,
- Good nutrition,
- Tobacco cessation,
- Alcohol in moderation, and
- Positive mental health."[1]

For more information:
http://michigan.gov/documents Healthy_Michigan_2010_1_88117_7.pdf

There are many initiatives to address smoking, alcohol abuse and other factors associated with chronic disease in Michigan and nationwide. However, for the purpose of this briefing report we will cover a **selection** from the many **programs** that address **healthy eating and physical fitness** in Michigan's children. Improving the health of Michigan's children and youth is important for their overall well-being and for the prevention of premature morbidity and mortality.

How is Michigan promoting healthy lifestyles?

Michigan State Board of Education Recommendations

The Michigan State Board of Education has adopted a number of recommended guidelines for local school districts on the promotion of health and physical activity. In Michigan, each local school district determines its own policies; therefore, the State Board of Education's guidelines are recommendations rather than rules.

- **Physical Activity** - all public schools promote health by offering high quality physical education opportunities, including: [2]
  - At least 150 minutes of instruction per week for elementary school students.
  - 225 minutes of instruction per week for secondary school students.
  - Time for unstructured physical activity each day for grades K-6.

For more information:
http://www.michigan.gov/documents HealthPolicyPE_77380_7.pdf

- **Healthy Food Choices** - ensure that healthy food choices are available in venues within the school/district's control such as: [3]
  - Vending machines, a-la-carte sales, food rewards, fundraisers, school stores, concessions, school parties, activities, and meetings.

For more information:
http://www.michigan.gov/documents
Healthy_Foods_AttchmtA_12_9_83141_7.pdf

- **Implementation of Coordinated School Health Programs (CSHP)** The CSHP model was proposed by the Centers for Disease Control and Prevention (CDC) in 1987 to help students achieve academic success by improving health. A school committee, which typically includes a representative from each of eight component areas that play a role in student health, assesses the school environment and develops school health priorities and programs.[4]

- **The State Board of Education recommended that**: [5]
  - Each school district develop a **comprehensive plan** for a Coordinated School Health Program.
  - Each school district establish a **District School Health Council and a School Health Team in each building**. They should represent a diverse array of students, staff, families, and community members.
  - The Michigan Department of Education provide **assistance to schools** so they can effectively implement their CSHP.

For more information:
www.michiganpta.org/www/pdf/CSHP%20Background%20Policy.pdf
www.michigan.gov/documents/CSHP_Policy_773755_7.pdf

Recommendations from Michigan Action For Healthy Kids (MAFHK)

Michigan Action For Healthy Kids is a state coalition of individuals and organizations working together to improve the nutrition and physical activity habits of children through school-based programs and interventions. The MAFHK coalition includes health and education professionals from over 250 organizations and is part of a nationwide initiative. For further information on the goals, objectives, and resource materials on MAFHK see www.actionforhealthykids.org and click on "Michigan" under "Select Your State."

- MAFHK, along with organizations throughout Michigan, encourages schools to complete the **Healthy School Action Tool (HSAT)**, an online assessment designed to help schools create healthier school environments. The development of HSAT was a collaborative effort of the Michigan Department of Community Health's Cardiovascular Health, Nutrition, and Physical Activity Section, the Michigan Department of Education, Michigan State University Extension, Michigan Team Nutrition, and the United Dairy Industry of Michigan.[6]

- The following **five recommendations** are from the HSAT Website on how schools can create healthier school environments. [7]

  1. *Implement recommendations from* **The Role of Michigan Schools in Promoting Healthy Weight**, *a consensus paper that addresses weight concerns about Michigan's children*
  2. Establish a Coordinated School Health Team in the school and join Michigan Team Nutrition www.tn.fcs.msue.msu.edu
  3. Complete the Healthy School Action Tool (HSAT)
  4. Use HSAT results to make policy and environmental changes
  5. Facilitate action in the community by joining Michigan Action for Healthy Kids

  For more information: http://www.mihealthtools.org

Programs and Initiatives

- A Michigan Action for Healthy Kids **"Healthy School" pilot project** is in progress. The project will implement and evaluate the nutrition and physical activity interventions recommended by the MAFHK, and provide conclusions to assess the practicality of executing these interventions in other Michigan schools.[8] Progress to date: [9]

  1. Two pilot schools were selected for the study.
  2. Each school has a Coordinated School Health Team and has completed the HSAT assessment. Each school has developed a specific action plan for improving nutrition and physical activity, based on its HSAT results.
  3. MAFHK expects that the outcome data will prove the effectiveness of the interventions and the viability of implementing them in other Michigan schools.

  For more information:
  http://www.actionforhealthykids.org/AFHK/team_centerteam_public_view.php?team=MI&Submit=Go

- The **Nutrition Education Aimed at Toddlers** (NEAT) research project was federally funded through the Department of Health and Human Services, Administration on Children, Youth, and Families (ACYF). The purpose of the intervention was to enhance toddlers' self-regulated feeding behavior and toddler-parent feeding interactions.[10]
  - The program served low-income families with toddlers in Early Head Start (EHS) programs from 28 Michigan Counties.[11]
  - 135 families were enrolled. Complete information was obtained for 43 parent-toddler pairs in the intervention group and 53 pairs in the non-intervention group.[12]
  - The program had two main components:[13]
    - Four NEAT classes taught by a trained paraprofessional nutrition instructor on meal planning and positive meal-time caregiver-toddler interactions.
    - Reinforcement Activities, which consisted of 18 weekly, short activities provided in each family's home by EHS home visitors.
  - Conclusion:[14]
    - Low-income EHS parents need support and direction in feeding their toddlers appropriately.
    - Findings show that parents in the intervention group had an increase in knowledge, although there is a potential for increasing parent knowledge about feeding toddlers.
  - The project was a collaboration between Early Head Start, Michigan State University, and Michigan State University Extension.[15]

  For more information:
  http://nursing.msu.edu/neat/executivesummary.html

- The **Soup and Salad Program** is a program for child care providers of low-income children. Grant money was awarded to 348 home and center-based child care providers by the **Michigan Community Coordinated Child Care Association (Michigan 4C)** with funds provided by the Michigan Family Independence Agency through a federal Community Food and Nutrition Grant.[16]
  - The program was designed to encourage healthy eating and to promote curiosity about gardening and its connection to healthy eating.[17]
  - Feedback from providers has been positive. Because of the grant, children were able to both grow and eat fresh vegetables.[18]

  For more information:
  http://www.michigan.gov/printerFriendly/0,1687,7-192-29942-102421—,00.html

- **Michigan Team Nutrition (TN)** is part of a nationwide USDA initiative designed to motivate, encourage, and empower schools, families, and the community to work together to continually improve school meals and make food and physical activity choices for a healthy lifestyle. In Michigan, TN is implemented cooperatively by the state of Michigan Department of Education and MSU Extension. More than 900 schools are enrolled as Michigan TN schools. Enrolled schools can apply for mini-grant and are provided with educational resources. Team Nutrition schools are using the Healthy School Action Tool to determine, implement, and evaluate school environment and policy changes to promote healthy eating and/or physical activity.[19]

  For more information:
  http://www.msue.msu.edu/fnh/tn/index.html

Information and public awareness

- Michigan Action for Healthy Kids (MAFHK) created a 30 second **public service announcement (PSA)** encouraging kids to make healthy choices. It was broadcast 40,000 times on cable stations early in 2004. Targeted toward teens, its message was, "Smart students make smart choices about healthy eating and being physically active."[20]

  For more information:
  http://www.actionforhealthykids.org/AFHK/team_center/team_public_view.php?team=MI&Submit=Go

- The **Healthy Kids Healthy Weight** publication represents a collaboration between the Michigan Department of Community Health and the Michigan Board of Education. The concept is to help families understand the importance of healthy weight in children. Several fact sheets from the booklet are available for download from the following site: http://www.emc.cmich.edu/healthyweight. Topics covered in the fact sheets include fit families and healthy eating.[21]

Promising Programs

Caregiver support

Family Caregiver Support Program in Pennsylvania

Primary Focus: To assist caregivers of elderly relatives or relatives with dementia

Program Description

The Family Caregiver Support Program was enacted in 1990 to help those who care for dependent relatives aged 60 and over, or relatives ages 18 to 69 with dementia. The program, which is only open to low-income persons, provides services such as family consultation/care planning, care management, emergency response, counseling, support groups and training.

The program takes a cost-sharing approach; income-eligible families may receive up to $200 per month to help with out-of-pocket expenses such as respite care. Also, one-time grants of up to $2,000 may be given to qualified families to modify the home or purchase devices to accommodate frail relatives.

Target Population

Pennsylvania residents with a household income level at or below 380% of the poverty level and who live with and care for dependent elderly relatives or relatives with dementia.

Impact

A study by Centers for Medicare & Medicaid Services in Baltimore found that the Family Caregiver Services Program serves approximately 3,500 families at any given time and about 6,500 different families per year. Costs average approximately $2900 per family for a full year of stay in the program and the average length of stay in the program is a little more than eight months.

Currently, the Pennsylvania Department of Aging is conducting a cost effectiveness study to determine the savings to the state that come from providing services to maintain people in their own homes.

For more information:

Division of Managed Care
Pennsylvania Department of Aging
555 Walnut St., 5th Floor
Harrisburg, PA 17101-1919
(717) 783-6213

http://www.aging.state.pa.us

For more information on the study:

Dan McGuire, Director
Bureau of Home and Community Based Services
Pennsylvania Department of Aging
(717) 783-6207

dcmcguire@state.pa.us

California Paid Family Leave Law

Primary focus: Partial pay for workers on family leave

Program Description

The California Paid Family Leave Law lets Californians take leave from work to care for a seriously ill parent, spouse, child or domestic partner, or to bond with a new, foster, or adopted child – and receive part of their weekly pay. Funded entirely by employees through the state's disability insurance program, the law allows employees to collect up to 55% of their salary for six weeks to care for their loved ones. Enacted into law in August 2002, it become effective in July 2004. California became the first state in the nation to develop a comprehensive paid family leave law.

Target Population

Californians who need to take time off from work to care for ill family members or newborn or newly adopted children

Impact

Researchers at the UCLA Institute of Industrial Relations are currently studying public attitudes toward, and awareness of, the new law, likely utilization rates, and perceptions of the impact on actual or potential leaves on careers and on the health of family members for the California Family Leave Research Project.

Before the law went into effect in July 2004, the Project found that public support for paid family and medical leave is extensive among all segments of the state's population, yet very few Californians are aware of the new paid family leave law. It also found that Californians have often taken family and medical leaves in the past, and many expect to need such leaves in the future.

For more information:

The California Family Leave Research Project

Labor Project For Working Families
2521 Channing Way # 5555
Berkeley, CA 94720
Tel (510) 643-7088
Fax (510) 642-6432

http://familyleave.ucla.edu/

http://www.paidfamilyleave.org

Cash & Counseling

Primary Focus: A choice-based alternative to traditional Medicaid-delivered services

Program Description

The overall goal of the Cash & Counseling program is to increase consumers' control over their personal care, thereby increasing satisfaction with care and reducing unmet needs without increasing public costs. The program allows elderly and disabled Medicaid consumers the opportunity to receive and manage a cash allowance to purchase personal assistance and related goods and services as an alternative to receiving agency-delivered supportive services. They may purchase personal assistance from sources other than Medicaid providers, such as family members or friends. Consumers receive assistance from money management counselors. The program is supported by the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services and started in 1995.

Michigan's Department of Community Health began a pilot Cash & Counseling program in September 2004 through a 3-year grant from the foundation. That

project will involve 600 consumers from the Michigan MI Choice waiver program to voluntarily work with state agency staff and advocates.

Target Population

Elderly and disabled Medicaid consumers

Impact

Mathematic Policy Research, Inc., with funding from the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, is conducting an evaluation of demonstration programs in three states: Arkansas, Florida, and New Jersey. The evaluation is looking at participation, implementation, benefits to consumers, and effects on public costs. Results from Arkansas indicated that the program greatly increased participants' satisfaction with care and reduced unmet needs. In addition, it did not adversely affect consumer health and safety. This and other promising results from New Jersey prompted expansion of the program to other states. Complete results of ongoing studies can be found on the Mathematica Website.

For more information:

Michigan pilot program:
Michael Head, Project Director
State of Michigan Department of Community Health
Lewis Cass Building
Lansing, MI 48913
(517) 335-0276

head@michigan.gov

Multi-state Evaluation:
Mathematica Policy Research, Inc.
P.O. Box 2393,
Princeton, NJ 08543-2393

www.mathematica-mpr.com/disability/cashcounseling1.asp

Obesity Reduction Programs

Girl's Health Enrichment Multi-Site Studies (GEMS)

Primary focus: Preventing excessive weight gain by African-American girls during puberty

Program Description

GEMS is a collection of studies designed to develop and test interventions to prevent excessive weight gain by African-American girls as they enter and proceed through puberty in four inter-dependent, clinical trials. There is an extremely high prevalence of obesity in black women, which may be contributing to their higher risk for diabetes and mortality from cardiovascular disease; this prevalence is present in childhood. The usefulness and effectiveness of a community-and-family-based behavioral intervention program to prevent and improve known cardiovascular disease risks in this demographic is under study.

Target Population

8-10 year-old African-American girls

Impact

The study began August 1999 and will not be completed until November 2006. The final component is the full-scale implementation of the intervention more broadly.

For more information:

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http://www.bsc.gwu.edu/bsc/studies/gems.html

GO GIRLS!

Primary Focus: Motivate overweight African-American girls to make healthy lifestyle changes

Program Description

The Go Girls! obesity prevention study in Atlanta addresses the fact that overweight adolescents are at greater risk for many chronic diseases as they grow older. It used motivational strategies aimed specifically at teens and developed appropriate strategies for healthy lifestyles that fit the population despite long-standing cultural attitudes. Researchers met with the adolescent girls twice a week. Girls underwent health evaluations and learned how to alter their physical activity and food intake levels to become healthier. This study was not designed as a rigorous efficacy study, but was developed to answer whether such a project could be carried out in a public housing setting and whether the intervention deserves a more formal evaluation.

Target Population

11- to 17-year-old African-American females who ranged from slightly overweight to 100 pounds heavier than recommended for their age and height.

Impact

Although general health and dietary practices improved in the girls, none of the changes achieved statistical significance. Despite limitations on implementation and its only modest effects, a formal field trial may be warranted, as the program showed promise.

For more information:

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http://www.whsc.emory.edu/_pubs/ph/phspr98/gogirls.html

Hip-Hop to Health Jr.

Primary Purpose: Test the effect of the intervention on change in body mass index in overweight/obese preschool African American and Latino children

Program Description

Obesity is a public health concern, especially among minority children. Effective strategies beginning in the preschool years are needed for overweight prevention. The objective of this trial was to assess the impact of a culturally proficient dietary and physical activity intervention on changes in body mass index (BMI). This was a randomized controlled trial conducted between September 1999 and June 2002 in Chicago. The study did not target overweight children specifically, but instead randomly selected children to prevent further weight gain by already overweight children and prevent future weight gain in normal children. The general intervention strategies were healthy eating educational activities and physical activity.

Target Population

Pre-Kindergarten 3-5 year old minority children in 24 Head Start Programs

Impact

Hip-Hop to Health Jr. was effective in reducing subsequent increases in Body Mass Index (BMI) in preschool children. This represents a promising approach to prevention of minority children becoming overweight in the preschool years.

For more information:

Marian L. Fitzgibbon, Ph.D.
Eating Disorders Research Program
710 N. Lake Shore Dr., Suite 1200
Chicago, IL 60611
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mlf056@northwestern.edu

http://chp.ilsi.org

Glossary

Disease Management Programs:	These initiatives are being tried as a lower-cost way to improve health care for people with chronic and disabling conditions, including many adult Medicaid beneficiaries. The goal of these programs is to assist people in maintaining or enhancing their health through self-care management and effective communication with their physician as well as to reduce treatment costs through better management. Some focus broadly on patient care management and lifestyle counseling; others focus primarily on managing pharmaceutical services. They have been tried for diseases such as asthma, cardiovascular disease, depression, diabetes. Early evaluations of Medicaid based programs show quality improvements but no large savings in the short-term. Sources: http://da.state.ks.us/ps/subject/healthquest/diseasemgt.htm_http://www.statecoverage.net/pdf/issuebrief1202.pdf
Federal Match Rate:	Also known as the Federal Medicaid Assistance Program (FMAP), it is the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 83 percent depending upon a state's per capita income. Across all states, the federal government pays an average of at least 57 percent of the costs of Medicaid. The FY 2005 match rate for Michigan was 56.71 percent. Sources: National Mental Health Association http://www.nmha.org/shcr/articles/glossary.cfm#F The Kaiser Family Foundation http://www.statehealthfacts.kff.org
Home and Community-Based Services (HCBS):	Services to maintain frail elderly and disabled persons in their own homes as an alternative to institutional placement. Most services are targeted directly toward the elderly or disabled person; family caregiver services are one component of this system of HCBS. Service may include a range of things, such as adult day care, respite care, chore services, counseling, home delivered meals, and personal care. Major funding sources include Medicaid, Title III of the Older Americans Act, and state and local funding streams. Source: Feinberg, Lynn Friss, *Family Caregivers: The Backbone of Long Term Care*
Informal Caregiving:	Caregiving is the act of providing assistance to someone who is ill or frail. Informal care is provided by a family member, friend or volunteer and consists of assistance with a range of activities, including hands-on help with personal care needs, running errands or assisting with transportation, helping to educate the consumer about his/her health and long-term care needs, and arranging and/or providing financial assistance for health and long-term care needs such as medications, doctor visits, and formal care. Sources: http://centeronaging.uams.edu/patients/informal_caregiving.asp www.caregiver.org

Long-term Care:	A range of health care services that are regularly used over a long period of time; sometimes over the course of a lifetime. Residence-based services, such as nursing home care, are one of the most common forms of long-term care and are what most individuals and policy makers have in mind when they speak of this type of care. Source: National Mental Health Association http://www.nmha.org/shcr/articles/glossary.cfm#E
Medicaid:	A nationwide health insurance program, adopted in 1965, for eligible disabled and low-income persons. It is administered by the federal government and participating states. The program's costs, paid for by general tax revenue, are shared by the federal and state governments. It is an entitlement program, meaning that all eligible persons may enroll; the federal commitment to match state spending is open ended. Source: National Mental Health Association http://www.nmha.org/shcr/articles/glossary.cfm#E
Medicare:	A nationwide, federally administered program that covers the costs of hospitalization, medical care and some related services for elderly and select other individuals. Medicare has several parts: Part A generally covers inpatient costs; and part B primarily covers outpatient costs. Pharmaceutical benefits have been excluded in the past but a Part D drug benefit was passed by Congress in 2003 and is scheduled to go into full effect in January 2006. Source: National Mental Health Association http://www.nmha.org/shcr/articles/glossary.cfm#E; www.cms.hhs.gov
Medicare Part D drug benefit:	A Medicare drug benefit was signed into law in December 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The coverage includes most FDA-approved drugs and biologicals, using the Medicaid coverage decision definitions. There are a few exceptions. Part D includes other items that aren't normally considered covered such as smoking cessation agents, vaccines and insulin, insulin-related supplies, such as syringes, needles, alcohol swabs and gauze, but not lancets and test strips. The full benefit will go into effect in January 2006. Sources: National Committee on Vital and Health Statistics Subcommittee on Standards and Security. http://ncvhs.hhs.gov/040330tr.htm#medicare Centers for Medicare and Medicaid Services www.cms.hhs.gov/medicarereform
MI Choice:	This began in 1992 as Michigan's Home and Community-Based Services Elderly and Disabled waiver program. It is now commonly known as the MI Choice Waiver Program. Through MI Choice, eligible adults who meet income and asset criteria can receive Medicaid-covered services like those provided by nursing homes, but can stay in their own home or another residential setting. Services include respite care, counseling, education and training for caregivers, home modifications, supplemental medical supplies and other services. Source: http://www.michigan.gov/mdch/0,1607,7-132-2943_4857_5045-16263—,00.html

National Family Caregiver Support Program:

Authorized by the amendments to the Older Americans Act of 2000, this program for the first time explicitly defined caregiver support as a responsibility of the aging services network. Jointly funded by federal and state matching funds, it provides information, assistance, counseling, training, respite care and supplemental services to family caregivers in recognition of the tremendous work that they do to care for their loved ones. Caregivers of any age may benefit from the program. While there is no income requirement, programs are required to serve the most vulnerable families first. In Michigan the program is administered by the Michigan Office of Services to the Aging and local Area Agencies on Aging.

Sources:
http://www.mdoa.state.md.us/Caregiving/NFCSPfacts.html
http://www.aoa.gov/prof/aoaprog/caregiver/caregiver.asp

Poverty Guidelines:

The administrative version of the poverty measure issued annually by the Department of Health and Human Services (HHS). They are frequently (incorrectly) referred to as the "federal poverty level." They are a simplification of the poverty thresholds and are used in determining financial eligibility for certain federal programs. A table of 2004 income levels can be found at the end of the glossary.

Source:
Institute for Research on Poverty (IRP)
http://www.ssc.wisc.edu/irp/faqs/faq7.htm

2004 HHS Poverty Guidelines

Size of Family Unit	1	2	3	4	5	6	7	8	For each additional person, add
48 Contiguous States and D.C.	$9,310	12,490	15,670	18,850	22,030	25,210	28,390	31,570	3,180
Alaska	$11,630	15,610	19,590	23,580	27,550	31,530	35,510	39,490	3,980
Hawaii	$10,700	14,360	18,020	21,680	25,340	29,000	32,660	36,320	3,660

Source: Adapted from information on the United States Department of Health and Human Services Website http://www.aspe.hhs.gov/poverty/04poverty.shtml

Additional Resources

Action for Healthy Kids

www.actionforhealthykids.org

Action for Healthy Kids (AFHK) is a nationwide organization that concentrates on improving the health and educational performance of children through better nutrition and physical activity in schools to combat our nation's epidemic of overweight, sedentary, and undernourished children and adolescents. AFHK is comprised of 51 state teams that focus on initiatives of action in their particular state, and a national coordinating and resource group. The Michigan State Team is concentrating their efforts to ensure healthful foods are provided throughout the entire school environment and that schools offer quality, daily physical activity. For Michigan's state team, visit http://www.actionforhealthykids.org/AFHK/team_center/team_public_view.php?team=MI&Submit=Go.

For more information contact:

Action for Healthy Kids
4711 West Golf Road, Suite 806
Skokie, IL 60076
(800) 416-5136

info@actionforhealthykids.org

American Academy of Pediatrics

www.aap.org

The American Academy of Pediatrics, a group dedicated to children's health, recognizes childhood overweight and obesity as a serious health concern. The Academy Website offers strategies for early identification of excessive weight gain by using body mass index, for dietary and physical activity interventions during health supervision encounters, and for advocacy and research.

For more information contact:

The American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007
(847) 434-4000
FAX (847) 434-8000

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. Policy information regarding prescription drugs, such as Medicare Part D, and Medicare-approved drugs programs are available. The CMS provides information on programs such as Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Clinical Laboratory Improvement Amendments (CLIA). These programs are committed to providing health coverage for low-income, elderly, and disadvantaged citizens. Health insurance and medical research topics can be accessed through the CMS website.

For more information contact:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
(877) 267-2323

Food and Drug Administration Dietary Guidelines

www.fda.gov

Because almost two-thirds of Americans are overweight or obese, the Food and Drug Administration's dietary recommendations for 2005 place a strong emphasis on calorie control and physical activity. The Food Guide Pyramid is undergoing revision and will be released spring 2005.

For more information contact:

U. S. Food and Drug Administration
5600 Fishers Lane
Rockville MD 20857
(888) INFO-FDA [(888) 463-6332]

The Future of Children

www.futureofchildren.org

The Future of Children promotes child welfare by producing timely and objectively researched publications on issues that affect children's health. The organization, which researches one or two topics per year, will complete a study of childhood obesity in 2006.

For more information contact:

The David and Lucile Packard Foundation
300 Second Street, Suite 200
Los Altos, CA 94022
(650) 917-9110
FAX (650) 947-8616

Kaiser Commission on Medicaid and the Uninsured

www.kff.org/about/kcmu.cfm

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. The Commission Website includes analysis on how the possible restructuring of Medicaid financing could impact states, providers, and beneficiaries. Begun in 1991, the Commission's work is conducted by Kaiser Family Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

For more information contact:

The Kaiser Commission on Medicaid and the Uninsured
1330 G Street, NW
Washington, DC 20005
(202) 347-5270
FAX (202) 347-5274

Maine's Coordinated School Health Program

http://www.mainecshp.com/

The Coordinated School Health Program is a collaborative effort between the Maine Department of Education and the Maine Department of Human Services that was designed to help connect health and education. The programs allows student to learn about health at school with the support of their families, schools, and community working together through intervention and prevention. The Michigan State Board of Education has recommended that each Michigan school district implement a similar plan in its district as well.

For more information contact:

Coordinated School Health Programs
Maine Department of Education
23 State House Station
Augusta, ME 04333
(207) 624-6696
FAX (207) 624-6691

National Academy for State Health Policy

www.nashp.org

The National Academy for State Health Policy (NASHP) is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice. The NASHP is focused on areas of health reform. These research areas include access for the uninsured, family and community health, the health care marketplace, long-term and chronic care, and health care purchasing strategies. NASHP publications on health care access and cost containment are also available through the website.

For more information contact:

NASHP
50 Monument Square, Suite 502
Portland, ME 04101
(207) 874-6524
FAX (207) 874-6527

National Governors Association

www.nga.org

The National Governors Association – the collective voice of the nation's governors – develops policy reports on innovative state programs and hosts networking seminars for state government executive branch officials. The association's research arm is in the midst of an initiative on aging in order to address long-term care, Medicare, housing, transportation, and workforce issues. It also released a publication on state aging trends that can be accessed at www.nga.org/center/databook04.

For more information contact:

National Governors Association
Hall of States
444 N. Capitol St.
Washington, D.C. 20001
(202) 624-5300

Texas's Coordinated Approach To Child Health (CATCH)

http://www.sph.uth.tmc.edu/catch/

CATCH is a school health program in Texas that unites parents, teachers, nutritionists, school staff, and communities to teach children and their families how to be healthy for their entire lives. The main guiding components are classroom health curriculum, physical education, nutrition guides, and family home team activities that reinforce healthy behaviors in a child's life and emphasize that health and learning are unified concepts.

For more information contact:

CATCH Texas
7320 N. Mopac, Suite #204
Austin, TX 78731
(866) 346-6163
FAX (512) 346-6802

The Urban Institute

www.urban.org

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that provides information and analysis to public and private decision makers in order to help them address social, economic, and governance problems facing the nation. Data concerning health insurance trends, child welfare, and indicators of economic well-being are available. Publications on a variety of pertinent issues such as health insurance coverage for children and Medicaid/SCHIP enrollment can be accessed online at www.urban.org.

For more information contact:

2100 M Street, N.W.
Washington, DC 20037
(202) 833-7200
paffairs@ui.urban.org

USDA's Team Nutrition

http://www.fns.usda.gov/tn/

Team Nutrition is an initiative of the United States Department of Agriculture Food and Nutrition Service to support the Child Nutrition Programs through training and technical assistance for food service, nutrition education for children and their caregivers, and school and community support for healthy eating and physical activity in schools. Using the Food Guide Pyramid and principles of the Dietary Guidelines for Healthy Americans, Team Nutrition strives to improve children's lifelong eating and physical activity behavior. For Michigan's state initiative website, go to http://www.msue.msu.edu/fnh/tn/.

For more information contact:

USDA's Team Nutrition
3101 Park Center Drive, Room 632
Alexandria, VA 22302
(703) 305-1624
FAX (703) 305-2549
tn@msu.edu

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About Family Impact Seminars

- Family Impact Seminars are nonpartisan educational forums on family issues for state policymakers.
- The seminars analyze the consequences to families of an issue, policy or program.
- The seminars provide objective non-partisan information on current issues. They do not advocate or lobby for particular policies.
- Briefing reports make scholarly findings available in an accessible format.
- A Legislative Advisory Committee selects issues for seminars based on emerging legislative need.
- National scholarly experts bring state of-the-art research on current family issues to policymakers.
- Webcasts make information available to those not able to attend the seminar.

For more information on Family Impact Seminars in Michigan, please contact:

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Michigan Family Impact Seminar Briefing Reports

No. 2000-1 *Child Care and Education*
No. 2000-2 *Children and Divorce*
No. 2001-1 *Promising Approaches for Reducing Youth Violence*
No. 2001-2 *Moving Families out of Poverty*
No. 2002-1 *What About Me? Children with Incarcerated Parents*
No. 2002-2 *Prostituted Teens: More than a Runaway Problem*
No. 2003-1 *Innovative State and Local Approaches to Health Coverage for Children*
No. 2003-2 *Across Challenging Terrain: Adolescents and Welfare Reform*

References

Executive Summary

1. Kids Count in Michigan, 2004 Data Book. Lansing, MI: Michigan League for Human Services.
2. Ibid.

A National Challenge: How States Are Trying to Control Medicaid Costs (And Why It's So Hard)

1. (January, 2005). Lansing, MI: House Fiscal Agency. www.house.mi.gov/hfa/
2. Ibid.
3. Hudman, J. & O'Malley, M. (2004, March). *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.
4. Williams, C. (2004, September). *Medicaid Disease Management: Issues and Promises.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.
5. Kaiser Family Foundation and Health Research and Education Trust. (2004). *Employer Health Benefits 2004 Annual Survey.* Washington, DC: The Kaiser Family Foundation. Retrieved on line December 10, 2004 at www.kff.org/insurance/7148/index.cfm.

Family Caregivers: The Backbone of Long Term Care

1. Thompson, L. (2004. March). *Long-term care: Support for family caregivers* (Issue Brief). Washington, DC: Georgetown University, Long-term Care Financing Project.
2. Arno, P.S. (2002). "The economic value of informal caregiving, U.S., 2000." Presentation at the annual meeting of the American Association for Geriatric Psychiatry, Orlando, FL, February.
3. Mittleman, S.H., Ferris, S.H., Shulman, E., Steinberg, G., & Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer's disease: A randomized controlled trail. *Journal of the American Medical Association, 276,* 1725-1731.
4. Feinberg, L.F, Newman, S.L., & Van Steenberg, C. (2002, November). *Family Caregiver support: Policies, perceptions, and practices in 10 states since passage of the National Family Caregiver Support Program.* San Francisco, CA: Family Caregiver Alliance.
5. Feinberg, L.F., Newman, S.L., Gray, L., Kolb, K.N., & Fox-Grage, W. (2004, November). *The state of the states in family caregiver support: A 50-state survey.* San Francisco, CA: Family Caregiver Alliance.
6. Feinberg, L.F., Hunt, G., Dawson, S. Trunham, H., Braunstein, D., Starns, M., & Cameron, J. (2004, June 24). *State support for family caregivers and paid home-care workers* (Issue Brief). Washington, DC: National Governor's Association, Center for Best Practices.
7. Foster, L., Brown, R., Phillips, B., Schore, J., & Carlson, B.L. (2003, March). *Does consumer direction affect the quality of Medicaid personal assistance in Arkansas?* Princeton, NJ: Mathematica Policy Research.

Additional References

- Feinberg, L.F. (1997). *Options for supporting informal and formal caregiving: A policy paper.* San Francisco, CA: American Society on Aging.

Michigan Programs to Support Family Caregivers

1. Statistics on demographics of the population and the value of caregiving come from *The State of the States in Family Caregiver Support: A 50-State Study. State Profile: Michigan.* San Francisco, CA: Family Caregiver Alliance (November, 2004). Available on line at http://www.caregiver.org/caregiver/jsp/home.jsp
2. Arno, P.S. & Mintz, S. (2004). Prevalence and economic value of family caregiving, state analysis 2000. Kensington, MD: National Family Caregivers Association.
3. Data source: Office of Consumer-Directed Home and Community-Based Services, Michigan Department of Community Health. (2003).
4. Family Caregiver Alliance, op.cit.
5. Data Source: Citizen's Research Council (2003).
6. Data Source: Marion Owens, Director, Tri-County Area Agency on Aging.
7. Family Caregiver Alliance, op.cit.
8. Ibid.
9. Ibid.
10. Family Caregiver Alliance, 2000 data. www.caregiver.org

Preventing Childhood Obesity: Controlling Medicaid Costs

1. ThompsUS Preventive Service Task Force, 2004, in press.
2. Task Force on Community Preventive Services: American Journal of Preventive Medicine 2002; Vol. 22, 4, S1, 67-72.

Additional Resources

- Baranowski T, Cullen KW, Nicklas T et al: School-based obesity prevention: a blueprint for taming the epidemic. Am J Health Behav. 2002 Nov-Dec;26(6):486-93.

- Campbell K, Waters E, O'Meara S et al: Cochrane Database Syst Rev. Interventions for preventing obesity in children.2002;(2):CD001871.
- Dietz WH, Gortmaker SL: Preventing obesity in children and adolescents. Ann Rev Pub Health 2001;22:337-353
- Fox KR: Childhood obesity and the role of physical activity**.** J R Soc Health. 2004 Jan;124(1):34-9.
- Gerberding JL, Marks JS: Making America fit and trim—steps big and small. Am J Public Health. 2004 Sep;94(9):1478-9.
- Mokdad AH, Ford ES, Bowman BA ET AL: Prevalence of obesity, diabetes, and obesity-related health risk factors, 2001.
- Reilly JJ, Wilson ML, Summerbell CD et al: Obesity: diagnosis, prevention, and treatment; evidence based answers to common questions. Arch Dis Child. 2002 Jun;86(6):392-4.
- St-Onge MP, Keller KL, Heymsfield SB: Changes in childhood food consumption patterns: a cause for concern in light of increasing body weights**.** Am J Clin Nutr. 2003 Dec;78(6):1068-73.
- Task Force on Community Preventive Services: Recommendations to increase physical activity in communities Am J Prev Med 2002;22:4:S1:67-72
- Wilson P, O'Meara S, Summerbell C et al: The prevention and treatment of childhood obesity. Qual Saf Health Care 2003;12:65-74

Policies and Programs to Promote Healthy Lifestyles among Michigan's Children

1. Paneth, N. (2005, February). *Preventing Childhood Obesity*. Presented in Michigan Family Impact Seminars, *Supporting Children and Families While Controlling Medicaid Costs*. Lansing, MI. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
2. Paneth, N. (2005, February). *Preventing Childhood Obesity*. Presented in Michigan Family Impact Seminars, *Supporting Children and Families While Controlling Medicaid Costs*. Lansing, MI. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
3. Paneth, N. (2005, February). *Preventing Childhood Obesity*. Presented in Michigan Family Impact Seminars, *Supporting Children and Families While Controlling Medicaid Costs*. Lansing, MI. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
4. Paneth, N. (2005, February). *Preventing Childhood Obesity*. Presented in Michigan Family Impact Seminars, *Supporting Children and Families While Controlling Medicaid Costs*. Lansing, MI. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
5. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
6. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
7. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
8. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
9. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
10. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
11. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
12. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
13. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
14. Michigan Surgeon General. (2004). *Health Status Report: Healthy Michigan 2010*. Lansing, MI: Michigan Department of Community Health, 19. Retrieved July 14, 2004: http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
15. Michigan State Board of Education. (2003, September). *Policy on Quality Physical Education*. Retrieved January 14, 2005 froms: http://www.michigan.gov/documents/HealthPolicyPE_77380_7.pdf

16. Michigan State Board of Education. (n.d.). *Policy on Offering Healthy Food and Beverages In Venues Outside of the Federally Regulated Child Nutrition Programs*. Retrieved January 14, 2005, from http://www.michigan.gov/documents/Healthy_Foods_AttchmtA_12_9_83141_7.pdf
17. Michigan State Board of Education (2003, September). *Coordinated School Health Programs ~ Background & Research*. Retrieved November 12, 2004, from http://michigan.gov/documents/CSHP_Background_Policy_77376_7.pdf
18. Michigan State Board of Education (2003, September). *Policy on Coordinated School Health Programs to Support Academic Achievement and Healthy Schools*. Retrieved November 12, 2004, from http://www.michigan.gov/documents/CSHP_Policy_77375_7.pdf
19. Healthy Schools Healthy Students (n.d.) Retrieved January 14, 2005, from http://mihealthtools.org/schools/Default.asp?tab=Home
20. Healthy Schools Healthy Students (n.d.) Retrieved January 14, 2005, from http://mihealthtools.org/schools/Default.asp?tab=Home
21. Michigan Action for Healthy Kids. (n.d.) Retrieved January 14, 2005, from http://www.actionforhealthykids.org/AFHK/team_center/team_public_view.php?team=MI&Submit=Go
22. Michigan Action for Healthy Kids. (n.d.) Retrieved January 14, 2005, from http://www.actionforhealthykids.org/AFHK/team_center/team_public_view.php?team=MI&Submit=Go
23. The NEAT Research Project. (n.d.). Retrieved February 8, 2005, from http://nursing.msu.edu/neat/executivesummary.html
24. The NEAT Research Project. (n.d.). Retrieved February 8, 2005, from http://nursing.msu.edu/neat/executivesummary.html
25. The NEAT Research Project. (n.d.). Retrieved February 8, 2005, from http://nursing.msu.edu/neat/executivesummary.html
26. The NEAT Research Project. (n.d.). Retrieved February 8, 2005, from http://nursing.msu.edu/neat/executivesummary.html
27. The NEAT Research Project. (n.d.). Retrieved February 8, 2005, from http://nursing.msu.edu/neat/executivesummary.html
28. The NEAT Research Project. (n.d.). Retrieved February 8, 2005, from http://nursing.msu.edu/neat/executivesummary.html
29. State of Michigan. (2004, October 18). *"Soup and Salad" Grants Provide Healthy Learning Experience for Kids in Daycare*. Retrieved January 14, 2005, from http://www.michigan.gov/printerFriendly/0,1687,7-192-29942-102421—,00.html
30. State of Michigan. (2004, October 18). *"Soup and Salad" Grants Provide Healthy Learning Experience for Kids in Daycare*. Retrieved January 14, 2005, from http://www.michigan.gov/printerFriendly/0,1687,7-192-29942-102421—,00.html
31. State of Michigan. (2004, October 18). *"Soup and Salad" Grants Provide Healthy Learning Experience for Kids in Daycare*. Retrieved January 14, 2005, from http://www.michigan.gov/printerFriendly/0,1687,7-192-29942-102421—,00.html
32. Michigan Team Nutrition. (n.d.). Michigan State University Extension. Retrieved January 14, 2005, from http://www.msue.msu.edu/fnh/tn/index.html
33. Michigan Action for Healthy Kids. (n.d.) Retrieved January 14, 2005, from http://www.actionforhealthykids.org/AFHK/team_center/team_public_view.php?team=MI&Submit=Go
34. Michigan Department of Education, Michigan Department of Community Health, The Governor's Council