STUDY RESULTS TO IMPROVE ADMINISTRATIVE EFFICIENCIES, SHARED SERVICES AND CONSOLIDATIONS

(FY2008 Appropriation Bill - Public Act 123 of 2007)

August 1, 2008

Section 272: (1) The department shall conduct a study of current policies and allocation methodologies to develop options that encourage administrative efficiencies within and among the following entities: (a) Local public health departments. (b) CMHSPs. (c) Substance abuse coordinating agencies. (d) Area agencies on aging. (2) The study should include a range of options including administrative efficiencies, shared services, and consolidations. (3) The department shall consult with at least the following applicable organizations in developing the study: (a) The Michigan association of community mental health boards. (b) The Michigan association of local public health. (c) The Michigan association of substance abuse coordinating agencies. (d) The area agencies on aging association of Michigan. (4) The department may expend up to $150,000.00 from the funds appropriated in part 1 to conduct the study. (5) The department shall submit the results of the study to the senate and house appropriations subcommittees on community health, the senate and house committees on health policy, the senate and house fiscal agencies, and the state budget director by August 1, 2008.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor

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Opportunities for Achieving Efficiency in the Aging, Community Mental Health, Local Public Health, and Substance Abuse Coordinating Agency Networks

August 1, 2008

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Michigan Legislature

Prepared on behalf of
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Lansing, Michigan

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Executive Summary

INTRODUCTION

Public Act 123 of 2007, Section 272, directs the Michigan Department of Community Health (MDCH) to conduct a study of the opportunities for achieving efficiency in the networks of community agencies that contract with the department: area agencies on aging, community mental health services programs and authorities, local public health, and substance abuse coordinating agencies. The Institute for Health Care Studies, College of Human Medicine, Michigan State University conducted the study and prepared this report on behalf of the MDCH.

STUDY METHODOLOGY

1. An overview was prepared to describe each network's statutory mandate, the current number and size of agencies in each network, the governance structure, the pattern of state financial support for each network over the last 20 years, and the major financing mechanisms and allocation methodologies.
2. Comments on opportunities, innovative practices, and barriers related to achieving efficiency were solicited and summarized from the four service networks.
3. An analysis was conducted of the amount and type of administrative costs incurred by each network, including the reporting requirements and the definitions in use.
4. Organizational structures for service delivery and promising practices in selected other states were reviewed and implications were identified for Michigan.
5. Options for consideration were proposed, based on the review of each network, the comments received, the review of promising practices and other states' service delivery models, and the analysis of administrative costs.

SUMMARY OF MAJOR FINDINGS

Key Trends in the Four Service Networks

- **Funding:** Over the last ten years, state General Fund increases for the four community health networks have fallen well below the 32 percent increase in the Detroit Consumer Price Index. While General Fund support has not kept pace with inflation, overall funding has increased primarily as a result of increased reliance on Medicaid funding; for example, Medicaid program expenditures represent 77 percent of the 2008 community mental health service program appropriation compared to 52 percent in 1998.
- **Service delivery:** Local public health continues to provide the most direct client services of the four networks. Aging and substance abuse networks primarily perform functions as intermediaries of state government, such as planning, provider recruitment, credentialing, and contracting and monitoring, rather than providing direct services to the target population. With increased reliance on Medicaid as a funding source, community mental health service programs (CMHSPs) are transitioning to an intermediary role, contracting with service providers.

- **Administrative complexity:** Local public health has the highest degree of administrative complexity due to the large number of programs provided. Local public health has worked closely with the MDCH to integrate contracting and other administrative functions to reduce redundant requirements and streamline reporting. The CMHSP transition to intermediary functions associated with financially at risk entities has resulted in extensive redundancy in quality assurance and auditing functions associated with service provider contracting.

Summary of Comments Received

The majority of those commenting responded with a resounding "yes" to the question about whether there are opportunities to improve the efficiency and effectiveness of the community health delivery system. Many types of opportunities were cited, including agency-specific innovations in programming, local collaborations across the service networks to address specific problems, mergers of one or more service networks, and changes in state policy, regulation, and administrative requirements. Respondents commented on the specific methods of increasing efficiency, e.g., sharing staff, co-location of services, and consolidating or sharing administrative functions such as billing and information system support. Respondents from all four networks emphasized that local service delivery systems have been adapting over time to better meet the service needs of their consumers while striving to increase efficiency. The majority of respondents also said that a single agency overseeing all services was not feasible and cited several reasons why.

Findings from Other States

A comparison of Michigan's organizational structure for the delivery of community health services with selected other states shows that the local network structures for public health and aging are very similar in Michigan and other states; substance abuse services are almost always located within a mental health department or bureau; and services for the developmentally disabled are almost always separate from mental health. Promising practices are under way in several states to standardize and streamline contracting practices, particularly regarding performance monitoring. Some states are striving to implement outcomes measurement and reporting systems and to link those reporting systems in a common data warehouse. Such efforts require substantial time and investment but have the potential for tying spending to results and generating data that helps policymakers more easily assess the benefits gained from investment.

OPTIONS FOR CONSIDERATION

The following options are offered for increasing administrative efficiency. For several of the options, there are network-specific options identified in Part IV of this report.

Option 1: Standardize Administrative Policies and Procedures

The MDCH could identify and better integrate administrative requirements driven by federal and state statutes and regulations and create common guidelines and tools to support integration of administrative functions across all four service networks, wherever possible.

Option 2: Account for Administrative Costs Consistently

The MDCH could develop a single, department-wide definition of administrative cost that is applied consistently across all service networks.

Option 3: Identify and Disseminate Evidence-based and Best Practices

The MDCH could establish an organized process for systematically identifying and disseminating evidence-based and best practices across community health services.

Option 4: Consolidate Structures

The MDCH could encourage consolidation of organizational structures among the four community health networks to increase administrative efficiency. This would require the elimination of statutory barriers and financial disincentives, and the reduction of political resistance, which would pose significant challenges.

Option 5: Increase Accountability for Outcomes

State government could begin the transition to a results-based accountability system to better determine the benefits of public investment, beginning with a targeted set of services, i.e., community health services, to design and launch the system, and with increased support to community collaborations that are creating local accountability for results.

I. Introduction

CHARGE TO THE MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Public Act 123 of 2007, Section 272, directed the Michigan Department of Community Health (MDCH) to conduct a study of the opportunities for achieving efficiency in the networks of community agencies that contract with the department: area agencies on aging, community mental health services programs and authorities, local public health, and substance abuse coordinating agencies. The department was required to consult with the following organizations in conducting the study: the Michigan Association of Community Mental Health Boards, the Michigan Association for Local Public Health, the Michigan Association of Substance Abuse Coordinating Agencies, and the Area Agencies on Aging Association of Michigan. The MDCH contracted with the Institute for Health Care Studies, College of Human Medicine, Michigan State University, to conduct the study and present the MDCH director with a report to satisfy the directive established by Public Act 123.

II. Study Methodology

OVERVIEW OF THE NETWORKS

The overview summarizes descriptions of the networks and identifies key trends. In Appendix A, a detailed overview is presented of each network's statutory mandate, the current number and size of agencies in each network, the governance of each type of agency, the pattern of state financial support for each agency over the last 20 years, and the major financing mechanisms and allocation methodologies.

NETWORK COMMENTS

Information was gathered from representatives of each of the service networks who chose to respond to a variety of methods to provide comments, i.e., one-on-one interviews, written responses to a series of questions, focus groups, and an online survey. Summaries of the comments provided were shared in feedback group meetings with the networks (Area Agencies on Aging Association of Michigan, Michigan Association of Community Mental Health Boards, Michigan Association for Local Public Health, and the Michigan Association of Substance Abuse Coordinating Agencies). Background information and comments were collected using one-on-one interviews, written comments, and interviews with legislative leadership, Michigan Department of Community Health (MDCH) administrators, judges, and county commissioners.

By network, comments were gathered in the following manner:

- Aging: written comments were provided by representatives of 14 of the 16 area agencies on aging (AAAs).
- Community mental health (CMH): Four focus groups were conducted with representatives of community mental health service programs (CMHSPs), prepaid inpatient health plans (PIHPs), mental health and substance abuse service providers, and substance abuse coordinating agencies (SACAs) operating within mental health systems. Written comments were received from nine of the 46 CMHSPs.
- Local public health: One-on-one interviews were conducted with seven health officers representing rural and urban health departments across the state.
- SACAs: Written comments were provided by the Michigan Association of Substance Abuse Coordinating Agencies and four of the 16 Substance Abuse Coordinating Agencies in the state. In addition, an online survey was completed by 84 individuals, the majority of whom were substance abuse service providers.

Summary of Comments

The summary of network comments presented in this report is based on the views of those who offered their perspectives. The responses have not been confirmed by objective review of fact. The comments are most useful in providing an understanding of the views and experiences of the four individual service networks. The findings are presented in three categories: consistent themes across all four networks, comments unique to each network, and comments from other stakeholders. Comments also describe

the innovative practices reported by the service delivery networks and were considered in the development of the options identified by the study.

ADMINISTRATIVE COSTS ANALYSIS

The analysis explores the actual and reported administrative costs of each network and describes the reporting requirements and the definitions in use. Based on the analysis, this report proposes points to consider in addressing issues related to administrative costs.

REVIEW OF ORGANIZATION STRUCTURES FOR SERVICE DELIVERY AND PROMISING PRACTICES IN OTHER STATES

At the suggestion of individuals who provided comments for the study and based upon a review conducted by the Institute for Health Care Studies, a summary of other states' organizational structures for service delivery and promising practices is presented in Appendix B.

OPTIONS FOR CONSIDERATION

Based on the review of each network, the comments received, the review of promising practices and other states' service delivery models, and the analysis of administrative costs, five options are proposed for consideration.

III. Overview of the Four Local Networks

SUMMARY OF THE LOCAL NETWORKS

From a historical perspective, local health departments (LHDs) have existed for almost a hundred years. They have evolved from a voluntary group of city, township, and county departments prior to 1965 to today's statewide network of 45 county/district (and the City of Detroit) departments. The other three networks began during the 1960s and 1970s, primarily in response to federal legislation and the availability of federal funding. The community mental health service programs (CMHSPs) were authorized in state statute in 1963, the area agencies on aging (AAAs) in 1975, and the substance abuse coordinating agencies (SACAs) in 1973.

The number of agencies within each network varies considerably. There are 16 AAAs, which serve as the agencies designated by the state unit on aging, as planning and service areas (PSAs) to develop and administer the area plan for a comprehensive and coordinated system of aging services. While the size and number of each AAA is not mandated by federal legislation, the establishment of PSAs is a federal mandate. An individual AAA cannot represent fewer than 80,000 residents who are 60 years of age and older. Michigan's 45 LHDs include 14 district health departments, 30 single-county health departments, and one city health department. The Public Health Code does not prescribe the number of LHDs, but it does provide that counties can merge together into a district health department upon approval of two or more county boards of commissioners. The substance abuse coordinating agencies are also established in the Public Health Code. Of the 16 agencies, eight are part of a CMHSP and three are part of a LHD. The 46 CMHSPS are similar to their LHD counterparts, in terms of their establishment and the method of consolidating with other counties as defined by the Mental Health Code.

The networks also vary in terms of whether they deliver services. Local public health is the only one of the four networks that has a primary role in service delivery. Conversely, the main role of the AAAs and the substance abuse coordinating agencies is to plan, contract, and monitor services on behalf of the state with providers. The CMHSPs are evolving as a system in terms of service delivery. They may provide direct services, such as group home operation, but their primary responsibility is to act as an intermediary for the state financed Medicaid capitation system. As an intermediary, they are responsible for contracting with and monitoring providers.

Appendix A provides a detailed overview of each of the four local networks, including information on the history of the local network, the statutory mandates and governance structure, other states' governance and funding structures, and a state appropriations history, as well as other information that is specific to each network.

KEY TRENDS AMONG THE FOUR NETWORKS

Michigan is experiencing a prolonged period of economic difficulty. In spite of numerous budget cuts enacted over the past several years, there continues to be a structural deficit at the state level and little taxpayer appetite for raising taxes. It is in this overall fiscal

context that the Michigan legislature requested a study of the opportunities to achieve greater administrative efficiencies within the four community health networks.

Interviews with legislative leadership indicated that the major reason for requesting this study was to have better information regarding administrative overhead that would permit meaningful comparisons between agencies within a network and across networks, the objective being to spend as much as possible on services without damaging the infrastructure that is necessary to support service delivery.

The opportunities for increased administrative efficiency need to be examined in the context of the potential for savings that may result in the state General Fund as well as the unique history and role of each local network. Overviews of each network present context for the consideration of the administrative efficiencies options identified in this report (see Options for Consideration, page 27). Based on the network overviews, the following major trends associated with funding, degrees of consolidation, service delivery, and administrative complexity have been identified:

Funding

- Over the last ten years increases in state General Fund support for these four networks have fallen well below the 32 percent increase in the Detroit Consumer Price Index (CPI). For instance, General Fund support grew by only 8 percent for CMHSPs, 2.9 percent for the substance abuse network, 7 percent for the aging network [excludes the Home and Community Based Services (HCBS) waiver], and the local public health operations grant declined by 2.6 percent. Combined, these four networks received a 2008 General Fund appropriation of $1.22 billion or 12.4 percent of the state's General Fund budget.
- While General Fund support has not kept pace with inflation, overall funding has increased primarily as a result of increased reliance on Medicaid funding. This is particularly the case with the CMHSPs, where today Medicaid program expenditures represent 77 percent of their overall appropriations compared to only 52 percent in 1998.

Degree of Consolidation

- The aging and substance abuse networks were highly regionalized from the beginning.
- On at least two occasions in the past the responsible state agency has recommended and taken steps to fold the substance abuse coordinating agencies into another network. In the early 1990s, there was an effort to combine them with local public health and more recently with CMHSPs.
- As a result, the substance abuse coordinating agencies are the most integrated of the networks, since eight of the 16 coordinating agencies are part of a CMHSP, and three are part of public health.
- The number of CMHSPs has declined from a high of 55 to 46 today. The 46 have affiliated into 18 prepaid inpatient health plans (PIHPs) for purposes of Medicaid funding.

- Over the years there has been a gradual trend to combine county health departments into district health departments that serve multiple counties. In 1989 there were 50 LHDs, as opposed to 45 today.
- The organizational structure of local health departments in other states is usually very similar to the structure used in Michigan. For example, our surrounding states also have a number of city and county health departments: Illinois-95, Indiana-95, Ohio-150, and Wisconsin-94.

Service Delivery

- Local public health delivers the most services directly, and in fact a single local agency may provide as many as 40 different services.
- Aging and substance abuse agencies perform functions as intermediaries of state government, such as planning, provider recruitment, credentialing, and contracting and monitoring, rather than providing direct services to the target population.
- With their increased reliance on Medicaid as a funding source, CMHSPs are a network in transition. They have converted to a financially at-risk Medicaid per capita payment model that operates similar to HMOs. In this role the CMHSPs do not deliver service directly but rather contract with local service providers.
- The aging network relies heavily on volunteer support.
- Since they were established by the federal Older Americans Act it is not surprising that the local networks in almost all states share more similar characteristics than the other networks, which have more state-specific origins.
- In most states the developmentally disabled population is not organizationally placed with other behavioral health services such as mental illness and substance abuse. A review of ten other states indicates that in only one instance were they located together.
- The local service delivery network for the developmentally disabled population is also different in other states. In three of the ten states reviewed, the state contracts directly with providers. In the other seven states a local network of county boards or nonprofits contract with providers.

Administrative Complexity

- Local public health provides an example of how a service network can accommodate complexity in funding, programming, and services. The wide range of services provided by local public health often represents unique categorical programs that include separate planning, delivery, and financial reporting requirements.
- The CMHSPs have transitioned to a primarily Medicaid funded system. In order to comply with the federal waiver requirements the CMHSPs and the affiliated PIHPs have become financially at risk entities. This in turn has resulted in a great deal of duplication and overlap in the quality assurance and auditing functions associated with monitoring the Medicaid providers. In other words, the same providers are under contract and audited by multiple PIHPs.

IV. Summary of Network Comments

CONSISTENT THEMES ACROSS THE FOUR NETWORKS

Consistent themes emerged from the comments received from each of the four networks; particularly two points emerged:

1. There are very positive attitudes about achieving greater administrative efficiency within the networks, and

2. Individual agencies have already identified and taken steps to increase administrative efficiency through various best practices, as described in the following summary.

The areas of consistent comments are organized by three key considerations: opportunities to improve the efficiency and effectiveness of the human services delivery system; innovative practices that could be shared across all networks; and barriers.

Opportunities to Improve Efficiency and Effectiveness

All of the service networks responded with a resounding "yes" to a question about whether there are opportunities to improve the efficiency and effectiveness of the human services delivery system. Many types of opportunities were cited, including agency-specific innovations in programming, local collaborations to address specific problems, mergers of one or more service networks, and changes in state policy, regulation, and administrative requirements. Respondents from all four networks emphasized, however, that local service delivery systems have been adapting over time to better meet the service needs of their consumers while striving to increase efficiency. As costs have risen and service needs have grown, human service agencies across the state have sought to develop more cost-effective service delivery systems, often with collaborative approaches utilizing diverse community resources. Most respondents stressed that it is important to begin discussion of how to increase administrative efficiency with an understanding of what is needed to maintain or improve the service delivery system. Moving to discussions on how to reduce costs through administrative efficiencies without this understanding was seen as a guarantee that human services clients would experience a decline in the quality and availability of the services they receive.

Regarding mergers or consolidations across and within networks to increase administrative efficiency, respondents said that a single agency overseeing all services was not feasible and cited several reasons for this:

- Federal and state mandates are unique for each network; there are differing missions and purposes.
- Different governance structures exist across the networks.
- Funding streams are separate.
- There are different professional standards and core competencies.
- Administrative practices vary across the networks.
- There would be political difficulties.

- Smaller agencies and programs would be subsumed and lose their capacity to serve clients.
- The quality of services and capacity to advocate for populations needing service would be diminished.
- Previous attempts have failed.
- Costs would be increased initially and perhaps no savings would result unless issues other than structural configuration are addressed.

Several respondents noted that the organizational placement of services for aging, mental health, public health, substance abuse prevention and treatment, and the Medicaid program in one state agency has not led to maximum policy and funding integration for health and human services and streamlining of administrative requirements across service networks.

Regarding the geographic boundaries of the four service networks, respondents noted that the varying boundaries present challenges and inefficiencies. Along with variations in administrative contracting and reporting requirements, the lack of common geographical regional boundaries makes consolidations across networks more daunting than consolidation within a single network. Several respondents said that any approach to alignment of regional boundaries across the networks should be based on where consumers go for services and should be locally initiated.

Respondents commented on the following specific methods of increasing efficiency, i.e., sharing staff, co-location of services, and consolidating or sharing administrative functions such as billing and information system support.

Sharing Staff

Overall, respondents said that there is opportunity for more effective staff sharing within and across service networks. Respondents in all four networks indicated that they already share staff when possible and appropriate, for example, specialized staff such as medical directors. Sharing staff is seen as a means to stretch resources and find staff for “hard to fill” positions. Many respondents noted that collaborations to share staff work best between agencies with common missions and clientele. Challenges to sharing staff include variations in credentialing required by the different service delivery systems, limited overlap in the types of skills required for each of the agency types, differences in personnel policies across agencies, and differences in the mix of volunteer and paid staff.

From a program perspective, the most frequently mentioned desired combination of services across all four service networks was mental health and substance abuse.

Co-location of Services

Many respondents across the networks said that co-location of services is a good method for enhancing efficiency and is already fairly common, particularly for community mental health (CMH) and substance abuse services. Housing the staff of one agency at another agency to provide centralized screening or intake and to facilitate referrals, information exchange, and ease of access to services for consumers served by more than one service network is currently used as a mechanism to enhance coordination of

services. Challenges to co-location include financial barriers and assuring privacy and confidentiality for clients.

Consolidating or Sharing Administrative Functions

Regarding shared administrative services, respondents said that it makes sense to consolidate or share billing systems, information technology, legal staff, payroll, purchasing, etc.

Innovative Practices

Many respondents identified programmatic and administrative areas where innovative practices have resulted in efficiencies and enhanced services for consumers and could create more value for the investment (i.e., better outcomes achieved more efficiently) if applied more systematically across all four service networks. Those innovative practices mentioned consistently across all four networks were:

- Integrating intake and case management processes for substance abuse, mental health, and public health services through co-location, cross training, and case management by a primary health care provider or another designated, single provider; creating services centered around the person
- Integrating administrative functions among agencies, including provider and client relations, after-hours service management, financing
- Determining and disseminating evidence-based and emerging best practices in both services delivery and administrative functions; state role should be enhanced and existing efforts such as local public health accreditation should be built upon to identify and disseminate best practices
- Returning savings accrued through innovation to service delivery
- Regional approaches, e.g., blending funding from different locales and across service networks for regionalized services and administrative functions, e.g., community health assessment, emergency preparedness, outreach and communications with the public, and specialized services
- Collaborations as a condition for funding
- Using satisfaction surveys to make adjustments in policies and practices

Respondents across all service delivery systems noted that a focus on cost effectiveness rather than cost savings is essential for achieving efficiency. Many noted that this is a much more difficult concept to grapple with because it requires understanding stakeholder expectations for human service delivery systems, which may vary. Respondents noted that cost effectiveness will not be achieved within the regional and local service delivery systems without instituting change at the state level, including the Michigan Department of Community Health (MDCH), the Michigan Department of Human Services (MDHS), the Michigan Department of Corrections (MDOC), and perhaps other departments.

Barriers

Respondents uniformly noted that state and federal statutory mandates, regulations, policies, and procedures are the foundation of the silo effect of human services delivery

systems at the local level. Many respondents noted that a fundamental premise of their service delivery systems is access to services at the community level and questioned whether more regionalization would create barriers for consumers seeking locally based services. Respondents from a number of service networks also said that there are barriers in the form of disincentives for further consolidation, e.g., the prohibition against case management and direct service within a single agency.

Commonly identified *local* barriers include:

- Lack of political will and/or resistance to integrate and regionalize
- Consolidation/merger costs money
- Data-sharing barriers

Commonly identified *state* barriers include:

- Lack of standardization in rate-setting methodology, contracting requirements, reporting and auditing requirements; burdensome administrative requirements
- State (and federal) statutes and regulations that don't work in concert (e.g., different definitions for administrative costs, state regions don't match up across the service networks)
- Lack of state leadership and direction for more uniform practices at the local or regional level
- Weak integration of policy and practice across the Michigan Department of Community Health and insufficient collaboration among state agencies
- Funding formulae encourage competitiveness rather than cooperation and collaboration
- Flat or declining funding—inadequate resources to meet existing needs

A summary of comments unique to each network is found in Appendix C.

V. Administrative Costs Analysis

INTRODUCTION

A great deal of interest has been expressed by legislators as to the amount and type of administrative costs incurred by each of the community health local networks. This section will explore the actual reported administrative costs of each network, the reporting requirements, and the commonplace definitions of administrative costs.

The Michigan Department of Community Health (MDCH) is required to report administrative costs pursuant to a section in the department's annual appropriations bill for three of the four local networks. The community mental health service programs (CMHSPs) and the substance abuse coordinating agencies (SACAs) have been reporting their overall costs, including administrative, to the MDCH for a number of years. Earlier this year the area agencies on aging (AAAs) reported their overall cost data for the first time, pursuant to a new requirement in the 2008 MDCH budget bill.

CMHSPs

Exhibit 1 provides a summary of the CMHSP expenditures for fiscal year 2006. This table was included as part of the MDCH's report required by Section 404 of the department's annual appropriations bill. The summary breaks out program costs (i.e., mentally ill, developmentally disabled, administrative, etc) for each agency. Overall administrative costs represented 7.4 percent of total spending. Administrative costs as a percentage of total spending range from a low of 0.75 percent for Central Michigan to a high of 15.55 percent in Monroe.

EXHIBIT 1
CMHSP Expenditures, FY 2006

CMHSP MI	Adult Cost	%	MI-Child Cost	%	DD Cost	%	Administrative Cost	%	Other Costs	%	Total Cost
Allegan	$5,298,519	30.20%	$966,238	5.51%	$8,998,461	51.30%	$1,246,128	7.10%	$1,032,740	5.89%	**$17,542,086**
AuSable Valley	2,450,567	19.77	360,805	2.91	6,349,447	51.22	1,439,327	11.61	1,796,926	14.49	**12,397,072**
Barry	1,899,431	36.43	580,680	1.14	2,146,896	41.17	467,653	8.97	119,973	2.30	**5,214,633**
Bay-Arenac	11,524,967	5.46	1,869,687	5.75	14,879,257	45.78	3,833,687	11.80	394,808	1.21	**32,502,406**
Berrien	9,136,872	34.74	1,474,551	5.61	14,854,415	56.48	725,112	12.76	108,375	0.41	**26,299,325**
Clinton Eaton Ingham	23,561,253	33.36	6,126,796	8.67	34,970,527	49.51	5,878,650	8.32	98,947	0.14	**70,636,173**
CMH for Central Michigan	16,639,861	27.55	4,385,545	7.26	38,370,128	63.52	453,229	0.75	557,502	0.92	**60,406,265**
Copper Country	5,177,411	37.42	769,790	5.56	6,570,517	47.49	386,541	2.79	930,575	6.73	**13,834,834**
Detroit-Wayne	217,475,694	39.29	30,414,331	5.49	185,539,718	33.52	47,059,524	8.50	73,021,464	13.19	**553,510,731**
Genesee	44,839,609	43.36	4,818,987	4.66	45,952,718	44.43	6,003,325	5.80	1,804,509	1.74	**103,419,149**
Gogebic	1,749,339	29.36	472,508	7.93	3,068,186	51.50	362,898	6.09	304,871	5.12	**5,957,803**
Gratiot	1,739,601	19.07	995,340	10.91	5,825,967	63.87	538,985	5.91	22,130	0.24	**9,122,023**
Hiawatha	6,020,401	39.09	1,406,964	9.13	7,044,445	45.74	280,017	1.82	650,676	4.22	**15,402,504**
Huron	3,188,272	137.12	589,597	6.86	4,457,208	51.90	275,020	3.20	78,666	0.92	**8,588,763**
Ionia	2,929,354	31.62	1,162,296	12.54	4,393,988	47.42	698,572	7.54	81,153	0.88	**9,265,364**
Kalamazoo	22,702,969	38.46	5,185,448	8.78	I22,308,374	37.79	6,647,359	11.26	2,183,092	3.70	**59,027,242**
Lapeer	4,772,358	36.38	616,966	4.70	7,516,957	57.31	120,826	0.92	89,665	0.68	**13,116,772**
Lenawee	7,497,378	44.04	970,877	5.70	8,348,145	49.04	207,039	1.22	0	0.00	**17,023,439**
Lifeways	14,509,287	39.96	I2,612,968	7.20	14,804,850	40.77	4,286,647	11.80	99,730	0.27	**36,313,482**
Livingston	6,188,202	36.64	1,767,086	10.46	8,266,772	48.94	252,958	1.50	415,633	2.46	**16,890,650I**
Macomb	48,827,156	30.40	5,481,466	3.41	76,874,708	47.87	10,628,065	6.62	18,786,209	11.70	**160,597,604**
Manistee-Benzie	3,621,789	30.85	1,224,978	10.43	6,054,653	51.57	839,702	7.15	0	0.00	**11,741,122**
Monroe	6,851,004	25.95	1,291,852	4.89	12,332,783	46.72	4,105,319	15.55	1,816,680	6.88	**26,397,638**
Montcalm	2,259,679	32.74	799,840	11.59	3,244,938	47.02	484,417	7.02	112,335	1.63	**6,901,208**
Muskegon	15,217,1601	35.63	1,450,001	3.40	21,913,008	51.31	3,580,905	8.38	546,284	1.28	**42,707,359**
Network 180	35,504,880	40.04	6,052,892	6.83	37,680,205	42.49	8,046,213	9.07	1,389,187	1.57	**88,673,377**
Newaygo	3,123,917	39.60	924,430	11.72	2,930,203	37.15	763,668	9.68	146,307	1.85	**7,888,525**
North Country	9,259,245	29.80	2,202,689	7.09	16,429,817	52.87	2,522,710	8.12	661,482	2.13	**31,075,943**
Northeast Michigan	4,626,785	22.93	712,967	3.53	13,082,283	64.85	676,433	3.35	1,075,116	5.33	**20,173,5841**
Northern Lakes	12,566,896	30.67	3,025,929	7.38	19,066,955	46.53	2,889,971	7.05	3,425,4591	8.36	**40,975,210I**
Northpointe	6,235,672	39.30	1,200,880	7.57	6,898,600	43.48	618,610	3.90	912,626	5.75	**15,866,387**
Oakland	83,450,191	35.09	10,310,993	4.34	126,349,617	53.13	14,324,815	6.02	3,358,627	1.41	**237,794,243**

CMHSP MI	Adult Cost	%	MI-Child Cost	%	DD Cost	%	Administrative Cost	%	Other Costs	%	Total Cost
Ottawa	$8,880,053	30.34%	$654,544	2.24%	$17,463,302	59.67%	$1,635,738	5.59%	$632,692	2.16%	**$29,266,328**
Pathways	9,462,839	23.81	2,233,538	5.62	18,791,653	47.28	4,609,431	11.60	4,645,500	11.69	**39,742,96**
Pines	2,338,786	28.26	745,959	9.01	4,770,860	57.65	419,986	5.07	0	0.00	**8,275,591**
Saginaw	17,059,230	38.34	2,324,283	5.22	19,074,243	42.87	3,509,330	7.89	2,524,713	5.67	**44,491,799**
Sanilac	3,898,352	24.65	573,279	3.62	11,005,374	69.58	298,071	1.88	41,342	0.26	**15,816,418**
Shiawassee	3,671,987	29.86	918,493	7.47	7,018,975	57.07	567,433	4.61	121,64011	0.99	**12,298,529**
St. Clair	11,277,392	27.55	3,392,787	8.29	21,995,572	53.74	3,545,759	8.66	720,901	1.76	**40,932,41**
St. Joseph	4,924,703	45.58	1,101,727	10.20	4,217,689	39.04	369,714	3.42	189,510	1.75	**10,803,343**
Summit Pointe	12,350,242	43.35	2,146,157	7.53	10,191,073	35.78	3,776,796	13.26	22,052	0.08	**28,486,320**
Tuscola	2,955,238	22.80	1,269,167	9.79	8,015,974	61.86	698,634	5.39	19,997	0.15	**12,959,010**
Van Buren	6,833,677	48.92	1,157,317	8.29	4,939,290	35.36	228,519	1.64	809,798	5.80	**13,968,601**
Washtenaw	19,757,145	38.55	2,258,671	4.41	19,528,847	38.11	4,660,160	9.09	5,041,931	9.84	**51,246,754**
West Michigan	5,822,898	38.22	1,941,596	12.74	6,183,988	40.59	951,573	6.25	335,596	2.20	**15,235,651**
Woodlands	3,487,500	38.84	680,359	7.58	4,307,528	47.97	267,540	2.98	236,200	2.63	**8,979,127**
Total	**$753,565,763**	**35.72%**	**$123,624,252**	**5.86%**	**$945,029,114**	**44.79%**	**$156,183,010**	**7.40%**	**$131,363,621**	**6.23%**	**$2,109,765,759**

SOURCE: MDCH, Section 404(2)(b) Per Capita Expenditures FY 2006, May 2007.

These types of variances among local agencies prompted the legislature to add section 460 to the Department's 2006 budget bill, requiring the MDCH to develop

> …definitions, standards, and instructions, for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by prepaid inpatient health plans (PIHPs), CMHSPs, and contracted provider systems that receive payment or reimbursement from …appropriated funds…[1]

In order to comply, the department has worked with the affected parties and embarked upon a rather lengthy and methodical implementation process. The purposes of section 460 were to formalize common definitions of administrative costs and to collect information from providers on their administrative costs. The MDCH implemented the new process in 2007 for the PIHPs and the CMHSPs. In 2008 the provider network will begin to implement the new reporting process.

AREA AGENCIES ON AGING

In March 2008, the MDCH published the breakdown of AAA costs mentioned above. The aging network was required by section 1417 of the 2008 MDCH budget bill to report overall revenues and expenditures by fund source and program activity. Exhibit 2 summarizes the reported administrative costs of the 16 AAAs for fiscal year 2007.

[1] Public Act 154 of 2005, Section 460 of the 2006 MDCH appropriations bill, online at *http://www.legislature.mi.gov/documents/2005-2006/publicact/pdf/2005-PA-0154.pdf.*

EXHIBIT 2
Area Agencies on Aging Costs, FY 2007

Agency	Admin Costs w/HCBS**	Total Costs w/ HCBS**	% of Total Costs	Admin Costs w/o HCBS**	Total Costs w/o HCBS**	% of Total Costs	Admin Costs FY07 Fin. Statement	Total Costs FY07 Fin. Statement	% of Total Costs	Admin Costs AAA Approp.***	Total AAA Approp.***	% of Total Costs
Detroit	$459,060	$25,417,103	1.81%	$459,060	$13,997,387	3.28%	$1,526,456	$23,276,182	6.56%	$459,060	$9,208,154	4.99%
Region I B	3,655,503	38,170,542	9.58	1,477,101	24,278,297	6.08	981,773	37,960,769	2.59	930,846	16,564,560	5.62
Senior Alliance	647,710	10,524,316	6.15	540,928	7,979,898	6.78	729,401	10,568,480	6.90	377,119	7,420,827	5.08
Region 2	1,298,794	9,087,019	14.29	485,667	4,709,911	10.31	189,516	9,087,019	2.09	124,539	2,543,297	4.90
Region IIIA Kalamazoo*	122,296	2,073,617	5.90	122,296	2,073,616	5.90	N/A	1,697,126	—	80,986	1,561,246	5.19
Region 3B	554,760	11,898,896	4.66	258,137	4,479,189	5.76	253,343	12,264,416	2.07	83,951	1,786,399	4.70
Region 3C Branch--St Joe	75,630	964,861	7.84	75,630	964,861	7.84	141,204	844,745	16.72	47,273	923,117	5.12
Region 4	577,804	10,265,570	5.63	412,639	4,969,484	8.30	3,065,719	10,261,417	29.88	131,771	2,518,233	5.23
Valley Area Region	499,718	7,686,721	6.50	418,649	4,281,400	9.78	434,081	7,160,059	6.06	217,234	4,194,871	5.18
Region 6	314,533	10,748,930	2.93	230,450	3,369,248	6.84	540,460	11,084,164	4.88	140,754	2,635,286	5.34
Region VII*	1,407,976	11,883,762	11.85	616,623	6,839,561	9.02	708,696	11,704,121	6.06	325,827	6,670,008	4.88
Western MI*	1,002,657	20,027,362	5.01	848,966	13,608,025	6.24	1,320,706	18,311,366	7.21	346,986	6,678,087	5.20
NEMCSA Region 9*	956,705	7,925,642	12.07	271,465	5,212,678	5.21	N/A	7,421,062	—	170,498	3,575,723	4.77
NW MI Region 10*	193,751	6,352,539	3.05	193,751	3,426,205	5.65	192,660	9,345,837	2.06	147,738	3,085,291	4.79
UPCAP	752,402	13,687,664	5.50	337,706	6,612,964	5.11	N/A	14,649,125	—	241,488	4,863,359	4.97
Senior Resources Region 14	1,332,794	9,458,371	14.09	167,468	4,209,306	3.98	1,824,964	9,458,371	19.29	153,129	2,735,465	5.60
Total	**$13,852,093**	**$196,172,915**	**7.06%**	**$6,916,536**	**$111,012,030**	**6.23%**	**$11,908,979**	**$195,094,259**	**6.95%**	**$3,979,199**	**$76,963,923**	**5.17%**

SOURCES: 2007 OSA Annual Report, FY 2007 or 2006 AAA Financial Statements, MDCH report, *Annual Expenditure Report for Area Agencies on Aging*, March 2008, required by Section 1417 of the 2008 appropriations bill. There are revenues and expenditures reflected in this chart that do not flow from OSA, which does not have authority over those sources.
*Financial Statements available were FY06.
**Costs as reported by AAAs to OSA—pursuant to section 1417 boilerplate report.
***2007 Appropriations to AAAs—grants only, w/o HCBS.
NOTE: N/A = not available.

Overall administrative costs represented 7 percent of total AAA expenditures. If Home and Community Based Services (HCBS) waiver costs are excluded, administrative costs decline to 6.2 percent. While excluding HCBS waiver costs makes little difference in the overall administrative rate, it does affect several of the individual AAAs rather significantly. Some of the AAAs included care management services under the HCBS program as an administrative cost, while others did not. For instance, Region 14 reported $1.2 million in administrative costs for the HCBS program and Detroit reported zero. (Waiver administration costs are not controlled or capped by OSA.)

Also included in Exhibit 2 is a series of columns that report administrative and total costs according to the agency's financial statements. Notably, not all of the financial statements include information regarding administrative or management costs. Some of the AAA administrative rates vary widely from the report submitted to the Office on Services to the Aging (OSA), and some are very close. The purpose of the comparison is not to argue that any one of the figures is right or wrong, but rather to point out that without adequate definition of administrative costs, comparisons among agencies may not be particularly meaningful. OSA has definitions of administrative costs approved by the Administration on Aging (AoA) for Older Americans Act funds.

For purposes of monitoring state appropriations, perhaps the most relevant information is included in the last three columns of Exhibit 2. These columns include administrative cost information for the traditional Older Americans Act programs. These programs are funded by a combination of state and federal dollars and are included in the "Community and Nutrition Services" appropriation unit in the MDCH budget bill. The OSA limits the amount of administrative funds to just a little over 5 percent.

SUBSTANCE ABUSE COORDINATING AGENCIES

Exhibit 3 summarizes the administrative costs of the substance abuse coordinating agencies for fiscal years 2001, 2006, and 2007.

EXHIBIT 3

Substance Abuse Coordinating Agencies Expenditures, FY 2001, FY 2006, and FY 2007

Agency	2001 Admin. Expenses	2001 Total Expenses	% of Total Expenses	2006 Admin. Expenses	2006 Total Expenses	% of Total Expenses	2007 Admin. Expenses	2007 Total Expenses	% of Total Expenses
Detroit Dept. of Health	$1,412,044	$28,983,881	4.87%	$3,386,426	$32,959,624	10.27%	$2,872,157	$30,609,364	9.38%
Eastern U.P./Pathways	302,633	3,173,862	9.54	272,090	3,581,477	7.60	225,000	3,530,249	6.37
Genesee County Health Dept.	631,954	7,784,226	8.12	692,146	8,254,824	8.38	446,733	7,494,596	5.96
Kalamazoo	445,742	4,158,211	10.72	590,945	6,626,092	8.92	617,749	6,452,008	9.57
Kent County/Network 180	346,869	7,817,486	4.44	715,990	8,638,384	8.29	832,106	9,145,443	9.10
Lakeshore	492,034	6,626,412	7.43	507,382	7,927,106	6.40	507,585	6,821,402	7.44
Macomb County	710,350	6,061,659	11.72	1,005,103	7,515,765	13.37	1,051,217	7,385,793	14.23
Mid-South Substance Abuse	817,445	9,879,690	8.27	876,294	11,202,873	7.82	945,386	11,351,577	8.33
Northern MI	1,192,498	9,385,496	12.71	1,043,892	11,075,430	9.43	1,057,936	9,775,524	10.82
Oakland	743,310	7,334,103	10.13	741,639	10,035,417	7.39	743,464	9,676,862	7.68
Riverhaven/BABH				512,583	3,949,808	12.98	513,810	4,266,144	12.04
Saginaw County Health Dept.	503,278	4,612,305	10.91	453,459	3,793,965	11.95	386,752	4,056,424	9.53
St. Clair	367,063	3,245,634	11.31	297,222	2,977,559	9.98	373,085	3,113,511	11.98
Salvation Army Harbor Light	204,850	5,093,819	4.02	—	4,239,231	0.00	—	4,241,105	—
SEMCA	1,004,774	14,149,448	7.10	854,067	12,267,131	6.96	793,476	11,659,618	6.81
Washtenaw	469,058	3,564,828	13.16	407,063	5,207,419	7.82	433,674	5,351,607	8.10
Western U.P.	266,212	2,637,271	10.09	270,882	2,155,890	12.56	296,927	1,954,651	15.19
Total	**$9,910,114**	**$124,508,331**	**7.96%**	**$12,627,183**	**$142,407,995**	**8.87%**	**$12,097,057**	**$136,885,878**	**9.12%**

Agency	2001 Admin. Expenses	2001 Total Expenses	% of Total Expenses	2006 Admin. Expenses	2006 Total Expenses	% of Total Expenses	2007 Admin. Expenses	2007 Total Expenses	% of Total Expenses
Fund Source:									
ODCP	$5,494,361	$75,092,770	7.32%	$6,342,379	$79,578,803	7.97%	$6,579,510	$74,403,550	8.84%
Medicaid	2,844,283	24,313,407	11.70	2,769,534	28,970,833	9.56	2,835,108	28,628,385	9.90
ABW (Federal Share Only)	—	—	—	14,880	1,773,760	0.84	21,042	1,703,913	1.23
MiChild (Federal Share Only)	—	—	—	23,519	156,044	15.07	330	43,796	0.75
SDA	—	6,317,294	—	—	2,443,326	0.00	—	2,422,647	0.00
Fees	93,091	5,579,786	1.67	85,222	2,841,569	3.00	76,123	2,633,464	2.89
Local	1,229,333	10,916,954	11.26	3,295,778	23,670,050	13.92	$2,426,832	$24,281,199	9.99
Federal	13,059	281,776	4.63	728	1,192,235	0.06	754	853,079	0.09
Other	235,989	2,006,342	11.76	95,145	1,781,376	5.34	157,358	1,915,843	8.21
Total	**$9,910,116**	**$124,508,329**	**7.96%**	**$12,627,185**	**$142,407,996**	**8.87%**	**$12,097,057**	**$136,885,876**	**9.12%**

SOURCE: MDCH, *Substance Abuse Prevention, Education, and Treatment Programs*, April 2008.

As a percentage of overall expenditures, administrative costs represented about 8 percent in 2001, slightly less than 9 percent in 2006, and just over 9 percent in 2007. In fiscal year 2007 total administrative and overall expenditures were $12.1 million and $136.9 million, respectively. The administrative rate as a percentage of total costs ranged from a low of 6.4 percent for Pathways to a high of 14.2 percent for Macomb County.

LOCAL HEALTH DEPARTMENTS

For a number of years the MDCH has not collected overall expenditure cost data from the local health departments (LHDs). The department does enter into contracts each year with LHDs, but the contract only includes costs that are associated with programs that are funded with state or federal pass-through dollars. Included in that contract are central administrative costs.

Exhibit 4 includes overall expenditure information obtained from a Michigan Association of Local Public Health (MALPH) database for fiscal year 2006 and administrative costs as reported in the 2007 LHD contracts. Unfortunately, however, six of the local health departments did not report their administrative costs. On average for the 39 LHDs that reported, administrative costs represented 14 percent of total costs. The rates ranged from a low of 4 percent in Kalamazoo to a high of 36 percent in Jackson.

EXHIBIT 4
Local Health Department Expenditures, FY 2006 and FY 2007

Health Department	2007 Admin Expenses	2006 Total Expenses	% of Total Expenses	Inflation Adj. 2007 Admin Expenses	% of Total Expenses
Allegan County	$430,146	$3,400,854	12.65%	$423,264	12.45%
Barry Eaton DHD	1,738,542	7,133,456	24.37	1,710,725	23.98
Bay County	484,916	3,249,364	14.92	477,157	14.68
Benzie-Leelanau DHD	214,525	2,304,500	9.31	211,093	9.16
Berrien County	1,519,178	7,067,284	21.50	1,494,871	21.15
Branch-Hillsdale-St. Joe DHD	553,184	6,861,224	8.06	544,333	7.93
Calhoun County	885,473	5,366,263	16.50	871,305	16.24
Central Michigan DHD	1,703,807	7,818,395	21.79	1,676,546	21.44
Chippewa County	990,417	5,924,248	16.72	974,570	16.45
Delta & Menominee DHD	886,586	4,022,778	22.04	872,401	21.69
Detroit	N/A	100,412,078	—	—	—
Dickinson Iron	567,305	2,181,554	26.00	558,228	25.59
DHD # 2	790,445	4,691,779	16.85	777,798	16.58
DHD # 4	880,477	5,128,623	17.17	866,389	16.89
DHD # 10	N/A	12,276,827	—	—	—
Genesee County	2,597,462	27,917,794	9.30	2,555,903	9.16
Grand Traverse	N/A	4,344,169	—	—	—
Jackson County	1,598,917	4,339,604	36.84	1,573,334	36.26
Huron County	409,072	2,404,069	17.02	402,527	16.74
Ingham County	2,864,350	32,263,905	8.88	2,818,520	8.74
Ionia County	364,243	1,549,977	23.50	358,415	23.12
Kalamazoo County Health & Human Services	462,346	11,337,819	4.08	454,948	4.01

Health Department	2007 Admin Expenses	2006 Total Expenses	% of Total Expenses	Inflation Adj. 2007 Admin Expenses	% of Total Expenses
Kent County	$4,639,526	$23,817,046	19.48%	$4,565,294	19.17%
Lapeer County	470,388	5,084,680	9.25	462,862	9.10
Lenawee County	333,098	2,651,261	12.56	327,768	12.36
Livingston County	533,386	3,473,260	15.36	524,852	15.11
LMAS DHD	N/A	6,555,911	—	—	—
Macomb County	2,598,645	28,476,388	9.13	2,557,067	8.98
Marquette County	843,609	4,123,754	20.46	830,111	20.13
Mid-Michigan DHD	1,153,845	6,057,463	19.05	1,135,383	18.74
Midland County	576,654	3,096,769	18.62	567,428	18.32
Monroe County	1,179,494	5,207,257	22.65	1,160,622	22.29
Muskegon County	N/A	7,482,545	—	—	—
Northwest Michigan Community Health Agency	1,706,079	16,887,789	10.10	1,678,782	9.94
Oakland County	5,192,224	43,328,011	11.98	5,109,148	11.79
Ottawa County	1,807,898	10,235,291	17.66	1,778,972	17.38
Saginaw County	1,163,602	14,061,623	8.28	1,144,984	8.14
Sanilac County	354,724	1,967,267	18.03	349,048	17.74
Shiawassee County	527,509	3,179,028	16.59	519,069	16.33
St. Clair County	N/A	10,453,016	—	—	—
Tuscola County	423,647	2,721,720	15.57	416,869	15.32
Van Buren County	657,180	4,737,752	13.87	646,665	13.65
Wayne County	6,640,320	40,158,581	16.54	6,534,075	16.27
Washtenaw County	1,712,967	11,647,582	14.71	1,685,560	14.47
Western U.P. DHD	916,448	6,110,523	15.00	901,785	14.76
Total Expenditures	**$53,372,634**	**$523,511,081**	**13.97%**	**$52,518,672**	**13.75 %**

SOURCE: MALPH Database of Budgeted Expenditures, 2006, and contracted budgets in the Comprehensive Plan and Budget Contract (CPBC), 2007.
NOTE: N/A = not available.

Administrative costs for LHDs may be the most difficult to define among the four networks, mainly because they provide so many direct services. It is easy to define the health officer, medical director, nursing director, rent, etc., as an administrative cost but it becomes more difficult when direct services are provided by an organization. For instance, is a nursing supervisor, who also sees clients in the clinic, an administrator or direct care provider? It is possible to develop an allocation methodology to split the costs, but that makes a complex process even more complicated.

The total administrative costs for LHDs may be the least relevant to state policymakers, since such a large share of their overall spending is covered by locally generated revenues. Local public health is the only one of the four networks that generates over 50 percent of overall revenues. The overwhelming share of state support for LHDs is the $38 million local public health operations (LPHO) grant, which covers funding for seven basic health services. In 2006 the state support for LPHO programs represented only 27 percent of the $140 million budgeted for these seven services by LHDs.

DEFINITION OF AN ADMINISTRATIVE COST AND/OR INDIRECT COST

The MDCH provides detailed instructions and forms to the CMHSPs and the coordinating agencies in an attempt to collect consistent data on administrative costs. In order to understand the complexity of this process it might be useful to review various definitions of administrative costs:

- CMHSP Instructions—"For purposes of reporting on the Section 460 Cost Allocation report, these are costs of running the PIHP/CMHSP programs that do not meet the classification of direct service costs. These will include both directly assignable costs and those that are not readily assignable. For reporting purposes "Administration" also includes a share of the allocated overhead costs."[2]
- Coordinating Agency Instructions—Administrative costs are defined as "expenditures of the coordinating agency, regardless of revenue source, that are not payments to the treatment or prevention service provider network for treatment or prevention services. Coordinating agency administration excludes administrative costs of service providers regardless of service or administration function. Any provider's indirect (if applicable), overhead, and management costs associated with delivering the service must be reported as program expenditures."[3]
- Federal Office of Management and Budget (OMB) Circular A-87—"In general, direct costs are those that can be identified specifically with a particular final cost objective. Typical examples of direct cost charges to a federal award are employee compensation; costs of materials consumed or expended, equipment and approved capital expenditures, or travel expenses. Indirect costs are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. The term "indirect costs," as used herein, applies to costs of this type originating in the grantee department, as well as those incurred by other departments in supplying goods, services, and facilities…"[4]

The purpose of quoting these definitions of administrative costs is to point out how difficult it is to provide consistent guidance to local agencies. Before these local agencies can even begin to identify direct versus indirect costs, they must first develop a central cost allocation rate that complies with OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments. The A-87 instructions would fill a large binder and are so technical that many units of government hire an outside consultant to prepare their plan.

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[2] MDCH, *Michigan Department of Community Health Cost Allocation Requirements for FY07* (Lansing, Mich.: MDCH, October 2006), 9.

[3] MDCH Office of Drug Control Policy instructions for the Administration Expenditures Report, Attachment B.3, 1. Online, available: *http://www.michigan.gov/documents/mdch/Att_B3_CA_ Admini_Expenses_Report_Instr_FY08_212233_7.pdf*.

[4] Federal OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Attachment E, State and Local Indirect Cost Rate Proposals. Online, available: *http://www.whitehouse. gov/omb/circulars/a087/a87_2004.html#atte*.

FEDERAL OMB CIRCULAR A-87

Federal Circular A-87 provides guidance to state and local governments in determining allowable indirect cost charges. State government, local units of government, and nonprofit human service agencies utilize indirect cost allocation plans as a tool to recover administrative overhead costs. State plans and federally designated "major local governments" plans must be submitted to the appropriate federal cognizant agency for approval. In Michigan's case, that agency is the Chicago office or Region V of the federal Department of Health and Human Services. Upon approval of the indirect cost rate the agency is allowed to use the rate to recover administrative costs from federal or state grants. The approved cost plan identifies indirect costs that include such central service functions as accounting, budget, human resources, legal, etc. The rate is usually calculated based on a percentage of total costs or total personnel costs.

An individual state or local unit of government may have a number of indirect cost rates. For instance, the state of Michigan has a statewide rate that covers the costs in the central service departments. Individual departments also have a cost plan that identifies the department-specific overhead rate. Local units of government operate in the same way. For instance, if an LHD receives a $100,000 immunization grant from the state, the county might take 2 percent off the top and the LHD might take another 3 percent in order to offset their respective overhead costs.

The OMB circular identifies principles that can be applied in determining the allowability of 42 different items of cost, such as accounting, employee compensation, advertising, auditing, public relations, fringe benefit cost, pension plans, professional services, training, and taxes. The items may be treated as direct or indirect but not both. For instance, if building occupancy is included in the indirect rate, then rent should not also be included as a direct cost.

Comparing indirect cost rates among local agencies may be a useful tool in examining appropriate administrative overhead costs, but caution should be exercised. One cannot assume that an indirect cost is the equivalent of an administrative cost. There may be administrative costs that are direct costs, like the building rent example mentioned previously. Simply comparing one agency's overhead rate to another's is also problematic, because the base against which it is applied might be very different (i.e., total costs or total personnel costs).

SUMMARY

This discussion underscores the complexity associated with the development of common definitions of administrative costs. It should also provide a framework to understand the level of difficulty and the administrative burden, in and of itself, associated with collecting this type of information. The following considerations form the basis for Option 2 (page 30), presented in this report. These considerations may be helpful to policymakers in future efforts to address the issues associated with administrative costs:

- Develop a simple statewide, or at the least, a department-wide definition of administrative cost. (This would have to be very general because of different federal requirements for different programs.)

- Be consistent in the application of a definition across local networks. For example, coordinating agencies are specifically instructed to treat providers' administrative costs as direct costs; this instruction is very different from the new process being implemented for CMHSP providers, which requires each CMHSP to report their providers' administrative costs as part of their own.
- Utilize Federal OMB Circular A-87 to develop principles and definitions.
- Several of the local networks do not provide direct services, but rather were set up to operate as a fiscal intermediary on behalf of the MDCH. That type of multi-layered system is inherently inefficient, but local PSAs are a requirement of the Older Americans Act.
- Rather than spending a great deal of time and effort trying to define and report on administrative costs, set a percentage or amount up front. For instance, the Office on Services to the Aging caps the amount of administrative costs that can be spent on community and nutrition services grants.
- Any time the collection of data involves self-reporting there will always be inconsistency. The inconsistency might be deliberate or it might indicate confusion.
- Before adding any new reporting requirements, keep in mind how much this might be adding to the administrative costs of the local agency.
- Make sure that the information requested is relevant.
- Each of the local networks has a very different mission and therefore it is difficult to make any useful comparisons between networks. It would also be inappropriate to try to implement a standard administrative overhead rate for all four networks.

VI. Options for Consideration

OPTIONS FOR CONSIDERATION

Five options are proposed for consideration, ranging from administrative efficiencies to accountability for outcomes, as follows:

- Option 1: Standardize administrative policies and procedures
- Option 2: Account for administrative costs consistently
- Option 3: Identify and disseminate evidence-based and best practices
- Option 4: Consolidate structures
- Option 5: Increase accountability for outcomes

Option 1: Standardize Administrative Policies and Procedures

The MDCH could identify and better integrate administrative requirements driven by federal and state statutes and regulations and create common guidelines and tools to support integration of administrative functions across all four service networks, wherever possible.

Each of the service networks is required to comply with administrative requirements based on federal and state statutes and regulations that govern the use of federal and state funds for services to the populations that the networks are mandated to serve. As a result, multiple systems for assuring accountability have emerged over time. While intended to assure accountability, these multiple systems (such as contracting, monitoring, auditing of programs and providers, and reporting) create challenges and disincentives for administrative efficiency in local service networks.

Uniformly, comments received by the study emphasized that while considerable administrative efficiency has been achieved by each of the four local service networks, there is significant potential to achieve greater efficiency through standardization and the reduction of duplicative administrative requirements, particularly in the community mental health and substance abuse networks. A frequent comment from service providers in these networks was that they spend time and resources responding to redundant contracting, oversight, and evaluation systems, which often focus on the same areas of performance.

The Michigan Department of Community Health (MDCH) could take the lead in identifying and integrating administrative requirements driven by federal and state statute and regulation and create common guidelines and tools wherever possible. Overall, the MDCH could enhance the standardization of administrative requirements by (a) undertaking a comprehensive assessment that identifies inconsistencies and redundancies in the administrative policies and practices driven by federal and state mandates and regulations across the four service networks and (b) developing common guidance and tools that integrate requirements at the state level, thus providing support for the local networks to identify and pursue more efficient administrative arrangements, such as shared staff or a single organization with the administrative capacity to serve multiple agencies, either within or across service networks.

Working collaboratively with local service networks, the MDCH has, in the past, effectively increased the standardization of administrative processes and tools. Local agencies would be encouraged to pursue increased integration of administrative functions if the state provided clear guidance and support, including start-up or transition funding, to establish shared billing and information systems, co-location of services, referral systems, cross-training, and guidelines for other administrative areas. Further development of contract templates, common definitions related to administrative functions and assurances (e.g., privacy and confidentiality policies), integrated auditing processes, and more use of online communication and reporting would all be forms of simplification that would make it easier for the agencies in the local networks to move toward increased integration and consolidation of administrative functions.

A key consideration in advancing standardization of administrative requirements is the variation in administrative complexity within each of the four service networks, driven by the mandates and functions of each network. While there is potential for increased standardization and/or integration of administrative functions with current mandates, the extent of that potential varies among the networks. The following specific options are offered for consideration.

Local Public Health

Local public health, mandated to deliver a wide array of programs and services, has worked with the MDCH over time to reduce the very high degree of administrative complexity that results from managing multiple programs and funding streams as well as extensive, categorical assurance requirements. The Comprehensive Planning, Budgeting, and Contracting process (CPBC) includes a single contract between the MDCH and local public health departments that combines the requirements of multiple, federal categorical programs. Local public health accreditation provides a single program assurance process for all local health departments across the state. Considerable administrative efficiency has been gained through these processes by establishing a single contract for multiple programs and assuring that program requirements are met through a single, routine accreditation review.

The opportunities for increased administrative standardization in local public health lie in sharing of administrative staff across multiple agencies, outsourcing administrative functions (e.g., billing systems), and implementing service models that regionalize administrative functions while service delivery is localized. Such opportunities can result in the creation of sustainable service delivery models where services operated by individual agencies may fail. The Northwest Michigan Community Health Agency, for example, has established a partnership with other local health departments throughout Michigan to create and expand access to comprehensive oral health services for children and adults with Medicaid and for other special population groups. A core professional and administrative capacity was developed to support an efficient dental clinic model; that capacity now resides in a nonprofit corporation: the Michigan Community Dental Clinics (MCDC). The MCDC works with partner health departments to create dental clinics and then it operates the clinics. Another example is the development of county health plans created to assure that very low-income, uninsured persons have access to a primary care physician, specialty physician services, a pharmacy benefit, laboratory

services, and radiology services. Local health departments support development of the county or regional structure. However, the specialized capacity to provide outreach and enrollment, member services, development and maintenance of a provider network, adjudication and payment of claims, case management services, and program management services has developed in only a few organizations; one such location is the Bureau of Health Plan Management Services in the Ingham County Health Department. Ingham County contracts to support the operation of 18 county/regional health plans serving 54 counties and an enrolled population of about 60,000. It is unlikely that it would be cost effective to develop and operate dental clinics and health plans on an individual health department basis.

Community Mental Health

Administrative standardization in community mental health has been influenced by the transition to managed care. The implementation of Michigan's new financing model that established the Medicaid Managed Specialty Services program for persons with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders led to several new administrative functions for community mental health services programs (CMHSPs). The CMHSPs affiliated into 18 prepaid inpatient health plans (PIHPs) to manage and deliver mental health services to the Medicaid population and perform functions guided by Medicaid requirements related to information systems, claims processing, financial management, and appeal and grievances procedures. Within CMHSPs, per the 2004 Michigan Mental Health Commission,[5] increased standardization could be sought in areas such as payment, billing, and computer systems and training could be provided in those areas. The commission report also noted that, while there has been some progress with clinical uniformity and data submission, there is inefficiency due to the absence of a standard method of collecting information from PIHPs, CMHSPs, and providers to meet the large number of administrative requirements.

A specific option related to CMHSPs is the integration of provider auditing. CMHSPs consider themselves to be at risk for services provided to Medicaid clients. This results in activities by all 46 agencies to audit providers to assure the delivery of contracted services. Many providers of behavioral health services are audited by several of the 46 CMHSPs. A specific option would be for the 46 CMHSPs to develop a single statewide system for auditing behavioral health service providers. With all 46 contributing to the cost of a single system rather than each conducting its own audits, there should be substantial savings. Certainly there would be savings to the audited service providers undergoing a single audit rather than many audits for the same activities.

Another specific option is to consider the integration of the managed care administrative responsibilities of the CMHSPs and PIHPs with other health plans, e.g., the Medicaid Qualified Health Plans and the local health plans that have emerged across the state. The local health plans, which are county and regional health plans that cover primary care for those who are not eligible for Medicaid Qualified Health Plans and not covered by health insurance, use integrated administrative services. The functions of outreach, eligibility

[5] Michigan Mental Health Commission, established by Executive Order 2003-24, report issued October 2004. Online, available: *http://www.michigan.gov/mentalhealth/0,1607,7-201--98116--,00.html*.

determination, enrollment, and facilitating a provider choice are examples of common administrative functions that could be integrated for increased efficiency.

Substance Abuse

Further consolidation of substance abuse administrative functions could be made based on the PIHP structure.

Aging

The area agencies on aging (AAAs) already benefit from efficiencies gained from administrative standardization. Highly regionalized as a result of the federal mandate, many agencies jointly carry out administrative functions, including contract development, training, and auditing of providers used by contiguous agencies. Opportunities for further integration of administrative functions and sharing administrative staff include purchasing, information technology, and human resources across aging agencies. For example, the MDCH could assist the local agencies by exploring with them the possibility of combining their employee health care benefit packages, i.e., sharing a risk pool. In fact, a strong suggestion from the AAAs was to explore the possible use of state purchasing pools for AAAs as a possible efficiency.

Further analysis

Other states may serve as examples of how Michigan might reduce administrative duplication and variation, as described in this report's review of organizational structures and promising practices (see Appendix B).

Option 2: Account for Administrative Costs Consistently

The MDCH could develop a single, department-wide definition of administrative cost that is applied consistently across all service networks.

Based on this study's analysis of administrative costs, recognition of the difficulties inherent in developing a common definition, and the limits of using administrative costs to compare agencies or service networks, the following range of specific options could be considered:

- Develop a single, MDCH-wide definition of administrative cost.
- Consistently apply the definition across all service networks.
- Utilize the cost principles established in Federal Office of Management and Budget Circular A-87.
- Cap the amount of allowable administrative cost up front. However, capping the amount without standard definitions as to what constitutes an administrative cost may result in game playing.
- Determine how any new reporting requirement will affect the administrative cost of a local agency.

Option 3: Identify and Disseminate Evidence-based and Best Practices

The MDCH could establish an organized process for systematically identifying and disseminating evidence-based and best practices across community health services.

Many comments emphasized the need for evidence-based practices to drive innovation in service delivery and that integration of administrative functions and service delivery should follow thorough analysis of cost-effectiveness that demonstrates maintained or improved client outcomes. Exploring and implementing a more systematic way to identify and disseminate evidence-based and best practices was consistently identified as a state role by all four service networks, presenting a clear opportunity for the MDCH to influence the efficiency and effectiveness of community health services. The MDCH could establish a partnership with the local service networks and the state's academic institutions to develop, identify, and disseminate information.

Should the MDCH pursue Option 5, outcome-based accountability, an efficient method for identifying and disseminating evidence-based practices is essential. There are existing processes in both public health and mental health that can be built upon to create an organized, state-level capacity to address evidence-based practices, including Local Public Health Accreditation, which could be used as a way of identifying effective practices.

Option 4: Consolidate Structures

The MDCH could encourage consolidation of organizational structures among the four community health networks to increase administrative efficiency. This would require the elimination of statutory barriers and financial disincentives, and the reduction of political resistance, which would pose significant challenges.

Integration of administrative functions that could address state and federal statutes and regulations is needed, as described in Option 1, but may not be sufficient to maximize efficiency and effectiveness of community health services. As described in this report, some efficiency has been gained through this type of process integration, and there is substantial potential for accelerating the integration of administrative and service delivery functions to achieve efficiencies and improve service delivery. Another option for consideration is the consolidation or merger of human service organizations. These options range from the consolidation of a single agency with another similar agency in the same network, e.g., two single-county local health departments consolidating into a district health department, to the consolidation of more than one type of agency with another type of agency, usually with a common geographic area, e.g., a community mental health services program consolidating with a substance abuse coordinating agency.

On a voluntary basis, agencies within networks have consolidated into large districts or organizations when county governments can find common purpose with their neighboring counties. There is no common pattern related to size of population or other objective factors that predict when these consolidations will be feasible or enduring. However, economic pressures at the county level may create incentives for further consolidations in the future.

There are two major types of barriers to structural consolidation, both within and across service networks: (1) statutory and regulatory requirements and (2) political resistance and financial disincentives. These barriers can be overcome, but require a combination of advocacy for statutory and regulatory change and administrative directives. Again, the

unique mandates, funding streams, and governing arrangements of each network contribute variably to the two major types of barriers to structural consolidation. Maintaining local ownership and funding is a more important consideration in some networks than in others, but loss of local support is a risk as networks are consolidated into even larger regions. The following specific options present opportunities and considerations for consolidation.

Aging

The area agencies on aging began as regionalized entities according to federal mandate and may have reached optimal consolidation from a geographic perspective. Opportunities do exist for merging service delivery in specific areas, such as combined outreach for aging and public health services. Likewise, enhanced coordination and collaboration across aging, mental health, and substance abuse could be pursued, e.g., a significant portion of the population with developmental disabilities (DD) is aging into the services of the area aging agency network. In fact, the aging of the DD population raises major issues regarding planning, as well as funding.

Local Public Health

Local health departments are entities of local government and have been moving toward increased structural consolidation over time in their own economic interest. There are remaining opportunities for further consolidation, depending on the will of local government and the financial benefit of doing so. One way to encourage further consolidation is for the state to establish a minimum population requirement for local health departments. This would be similar to the current requirements for area aging agencies, which cannot represent fewer than 80,000 residents who are 60 years of age and older and the prepaid inpatient health plans for behavioral health services, which cannot serve fewer than 20,000 covered Medicaid beneficiaries.

Currently there are 13 local health departments serving populations of less than 75,000 and an additional four between 75,000 and 100,000. Although all 45 local health departments maintain accredited status, it is clear that smaller departments struggle to attract and support required and needed professional resources. Consolidation into larger units or developing opportunities to share scarce and valuable resources will be important to maintain required levels of prevention and protection in many communities.

An option for consolidating functions across service networks would be to build on the community health assessment function of local health departments. As the state continues to consolidate community health and substance abuse services into fewer, and larger, agencies, this option would rely on local health departments to engage communities in learning about health problems (including substance abuse and mental health) and to facilitate community involvement in development of strategic plans to address problems. Local health departments have a statutory duty to “utilize vital and health statistics and provide for epidemiological and other research studies for the purpose of protecting the public health” [MCL 333.2433(2)(b)]. The aging population, persons with substance abuse problems, and persons with mental illness certainly fall within the definition of public health. Development of this option would require investment in additional resources in the local health network, but it should result in a more efficient system of

identifying needs and strategies, engaging communities, and supporting enhanced community accountability for identifying issues and developing solutions.

Community Mental Health

Given the transition of community mental health to managing services through PIHPs, an analysis is in order of the most cost-effective organizational units for that function. The CMHSPs have affiliated to create 18 PIHPs and that structural transition could serve as a model for further consolidation efforts. As with PIHPs and the area agencies on aging, another option to encourage further consolidation might be to establish a minimum population for CMHSPs.

Regarding the developmentally disabled, Michigan has a long-standing history of integrating the delivery of mental health services and services for the developmentally disabled (DD) at the state and local levels. Other states have chosen very different delivery models that include DD services as a stand-alone department or agency, or the integration of DD with other long-term care services. In the latter instance, there are some states where the aging agencies manage the Home and Community Based Services waiver program for the DD population. The MDCH could review other states' long-term care systems, and, in particular, how the single point of entry systems are being implemented. Michigan is just beginning to implement the single point of entry system for the physically disabled and frail elderly populations. As the MDCH moves forward, it would be useful to examine the experience of other states and what they may have learned that may be transferable to Michigan's DD population.

Substance Abuse

Integration of substance abuse and community mental health services has been occurring at the local level. Eight of the 16 Substance Abuse Coordinating Agencies (SACAs) currently are located within CMHSPs. All of the SACAs must be affiliated with a PIHP in order to receive the funds to support services for the Medicaid population. The continued integration of substance abuse and community mental health would be advanced by requiring consistent geographical boundaries for the coordinating agencies and the PIHPs. There are instances where a single county may join a different PIHP than the rest of the counties in a coordinating agency region.

One innovation mentioned by those providing comment on the study was the integration of substance abuse (and mental health) services with the delivery of primary health care. The wider application of mental health's person-centered care was noted as a practice that could be extended to all community health services. An example would be integrating the intake processes for mental health, public health, and substance abuse treatment and designating case management to a primary health care provider—in other words, arranging and providing services with the person at the center of the process.

The Issue of Multiple Regional Boundaries

The challenges created by variation in the geographic composition of regional boundaries across the local networks were highlighted by many who provided comment for this study. Many benefits were identified from increasing the consistency of jurisdictional boundaries among the four local networks, such as reduction of administrative

duplication and more collaborative and efficient community assessment and planning. The MDCH could establish clear criteria for regional configurations and facilitate joint local and state movement toward increased consistency of network boundaries. The criteria could be based upon the integrated administrative requirements that would result from implementing Option 1, above.

Further Analysis

It is beyond the scope of this study to identify the specific statutory and regulatory barriers to the options presented for consideration.

Option 5: Increase Accountability for Outcomes

State government could begin the transition to a results-based accountability system to better determine the value of public investment, beginning with a targeted set of services, i.e., community health services, to design and launch the system, and with increased support to community collaborations that are creating local accountability for results.

There are a variety of ways to improve performance and accountability that can be used at various levels such as program, agency, and the community overall. Results-based accountability systems include values, desired outcomes, and quantifiable measures that enable decision-makers to assess progress. Target levels of performance to produce the outcomes are laid out along a pathway of proven steps or interventions and defined in measurable terms and specified time frames. These steps or interventions become the basis for performance contracting. Such contracting, which has been implemented in a few states, allows for payment based on the target levels of performance that are tied to outcomes. Results-based accountability also provides great opportunity for increasing both the efficiency of data reporting and the utility of that data, particularly when technology is fully utilized. Based on the experience of other states, data on performance linked to results can be organized in a transparent and accessible way, so that programs and local and state policymakers have easier access to useful information.

Regarding the issue of useful data for decision makers, some Michigan communities are creating community-wide indicators of well-being and identifying and using data that is meaningful in tracking progress toward the outcomes that are shared by not only community health and other human service organizations, but also the business community and nonprofit organizations that have become part of a single, community accountability system. These communities are undertaking special efforts to disaggregate data for use at the county and even the neighborhood level. As state government moves forward to increase accountability for outcomes, there could be increased support of local collaborations that make local accountability systems possible. Considerations for the kind of support the state might provide could include tying funding to performance measures for collaborative processes, simplifying administrative data reporting and removing barriers to sharing data (as noted in Option 1), and disseminating best practices of communities moving in the direction of local accountability systems.

Many comments received by the study stressed the importance of the state committing to ongoing analysis of service delivery efficiency and effectiveness, rather than relying on one-time studies. Local initiatives moving toward results-based accountability were cited,

with communities identifying outcomes mutually sought by multiple systems (including the private sector), using common indicators of progress, and integrating efforts and resources to get better results. This is particularly relevant to community health services and human services in general, where problems are highly interrelated and systems must work in tandem to be effective.

The State of Michigan could begin the transition to results-based accountability by developing the process in one area, such as one or more of the four community health service networks. The existing functions of the networks, such as local public health community health assessment, and community mental health performance measurement, could be built upon, as well as the initiatives to ease data sharing across systems, such as the regional health information networks. The local initiatives already under way should work together to devise Michigan's system. MDCH leadership, perhaps in partnership with sponsors in the philanthropic community, would be key to getting started.

Appendix A:
Overview of the Four Local Networks

OVERVIEW OF AREA AGENCIES ON AGING

The Office of Services to the Aging (OSA) is the state agency responsible for carrying out the responsibilities of the Older Michiganians Act (OMA) and the federal Older Americans Act. The mission of the OSA is to "promote independence and enhance the dignity of Michigan's older adults and their families."[6]

The OSA contracts with 16 regional area agencies on aging (AAAs) to plan, coordinate, and fund older adult services in specified geographic regions of the state. "AAAs contract for the delivery of services through local provider organizations. These aging network service providers offer a range of community-based, in home, housing, legal services, support for grandparents raising grandchildren, home delivered and congregate meals, employment programs, respite care, and long term care advocacy and assistance for nursing home residents and families."[7]

History

Federal

In 1965 Congress enacted the Older Americans Act. The mission of this law was to help older people maintain maximum independence in their homes and communities and to promote a continuum of care for the vulnerable elderly. It established the Administration on Aging at the federal level and required that each state designate a state unit on aging.

A background paper published by the National Health Policy Forum in April of this year describes the evolution of the Older Americans Act:

> The 1965 Act represented a turning point in financing and delivering community services to the elderly. Before then, federal and state governments played a limited role in providing social services and long-term care to older people. The Act's reach has evolved significantly through the years. Initially, it created authority for the then-new Administration on Aging (AoA) within the U.S. Department of Health and Human Services (DHHS) as well as state agencies to be responsible for community planning for aging programs and to serve as catalysts for improvement in the organization, coordination, and delivery of aging services in their states… Over the years Congress expanded the scope, authority, and responsibilities of these agencies. The original legislation authorized generic social service programs, but in successive amendments, Congress authorized more targeted programs under various titles of the Act to respond to specific needs of the older population. In 1973, Congress extended the reach of the Act by creating authority for sub-state "area agencies on aging" to be

[6] Michigan Office of Services to the Aging, 2007 Annual Report, *Partnerships for a Growing Aging Population* (Lansing, Mich.: OSA, January 2008), 1.
[7] Ibid., 3.

responsible for planning and coordination of a wide array of services for older people, as well as serving as advocates on their behalf.[8]

State of Michigan

Michigan followed the lead of the federal government and passed its own comprehensive aging statute in 1980, the OMA. The OMA was preceded by a number of committees, reports, and legislative actions that are summarized below.

- 1949—Governor G. Mennen Williams appoints an Interdepartmental Committee that recommends the establishment of a citizen's commission on aging.
- 1960—Commission on Aging established in statute and begins operations.
- 1973—Public Act 106 establishes a temporary two-year Commission on Aging and an Office of Services to the Aging. During the two-year period the commission and the office document the needs of the aging population and develop specific recommendations to address those problems.[9]
- 1975—Public Act 146 establishes a permanent Commission and Office of Services to the Aging.
- 1980—Older Michiganians Act replaces the 1975 statute. The new act lays out the duties of the commission, the office, and the area agencies on aging.

Statutory Mandates and Governance Structures

Today Michigan's aging services network is still governed by the federal Older Americans Act as well as the Older Michiganians Act. The Older Americans Act requires the governor in each state to designate a state agency to plan and coordinate services to the aging. The state agency is responsible for dividing the state into planning and service areas and then designating "area offices on aging."

The OSA is Michigan's designated state unit on aging for the purposes of the Older Americans Act. It is an autonomous state agency within the Michigan Department of Community Health (MDCH). The governor, with the advice and consent of the Senate, appoints its director.

The responsibilities of the OSA include administering federal and state funding for services in local communities, monitoring the provision of services, and evaluating state policies affecting older adults. The office is also responsible for program development activities and federal and state advocacy efforts.

The Commission on Services to the Aging (CSA) is a 15-member bipartisan group appointed by the governor with the advice and consent of the Senate. No more than half of its members may be of one political party and at least half must be at least 60 years old. The commission advises the governor, legislature, and the OSA on matters related to policies and programs for older adults in Michigan. It is responsible for designating the

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[8] National Health Policy Forum-George Washington University, *The Aging Services Network: Accomplishments and Challenges in Serving a Growing Elderly Population* (Washington, D.C.: National Health Policy Forum-George Washington University, April 11, 2008), 4.

[9] Michigan Office of Services to the Aging, 1990 Annual Report, *The Michigan Experience* (Lansing, Mich.: OSA, n.d.), 5.

AAAs and must approve the annual state plan required by the federal Administration on Aging.

The State Advisory Council on Aging (SAC) is a 40-member council appointed by the CSA. The SAC studies aging issues and recommends policy to the commission. It also serves as a communication link between local communities, the CSA, and the OSA.

The 16 AAAs are regional planning, advocacy, and administrative agencies designated by the CSA. Pursuant to the Older Americans Act, each agency must serve a population of at least 80,000. AAAs are run by local boards of directors, most of which are appointed by county boards of commissioners and other local government officials. Fifteen of the AAAs are private nonprofit corporations created by coalitions of county and local governments. Region 3C is a health department, Regions 9 and 11 are community action agencies, and Region 6 is made up of five governmental units: City of Lansing, East Lansing, and Clinton, Eaton, and Ingham Counties.

Thirteen of the AAAs represent multi-county jurisdictions. The three exceptions are Detroit, Wayne County, and Kalamazoo County. The Detroit AAA represents the cities of Detroit, Hamtramck, Highland Park, Harper Woods, and the Grosse Pointes. The Senior Alliance AAA serves the portion of Wayne County not included in the Detroit AAA. The Kalamazoo AAA is a division within the county's Department of Human Services.

Other States' Governance and Funding Structures

The nation's "aging services network" consists of 56 state agencies on aging, 655 area agencies on aging, 233 tribal and Native American organizations, and 30,000 local service provider organizations. In addition to the Older Americans Act, the network also administers a number of other federal, state, and local funding sources. These federal sources may include Medicaid, the Social Services Block Grant, the State Health Insurance Program, and the Department of Labor (Senior Community Service and Employment Program).[10]

The National Health Policy Forum background paper reports that

> about half of the state agencies are located in state health and /or human service agencies. Others are independent departments or commissions of state government. The governance of area agencies on aging varies widely. According to a 2006 study, 41 percent of area agencies were private nonprofit organizations, 32 percent were part of county or city governments, 25 percent were part of councils of government, and 2 percent were Indian Tribal organizations or other entities.[11]

In 1981 Congress added Section 1915(c) to the Social Security Act, thereby authorizing what is known as Medicaid Home and Community Based Services (HCBS) waiver programs. The purpose of the waiver programs was to provide Medicaid reimbursement for community-based services, thereby encouraging states to move away from more costly institutional placements.

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[10] National Health Policy Forum—George Washington University, op. cit., 5.
[11] Ibid., 9.

Many states utilized the existing aging networks to assist in the administration and delivery of these services. These Medicaid waivers may include elderly and younger people with disabilities. The National Health Policy Forum paper reports that

> according to a 2004 survey, state agencies on aging in 33 states were the designated operating agencies for the waiver programs: in 21 states they administered the waiver for both the elderly and younger people with disabilities, and in 12 states they administered the elderly populations only."[12]

Michigan received approval for its HCBS waiver program in 1990. The waiver program is administered at the state level by the Medicaid state agency (MSA) and at the local level it is administered by 14 AAAs and seven other entities.

The fiscal year 2008 appropriation for the Older Americans Act is $1.924 billion. Funding is appropriated according to the seven titles spelled out in the act (see Exhibit A-1). All of the titles are administered by the federal Administration on Aging within the Department of Health and Human Services, except for the employment program, Title V, which is administered by the Department of Labor.

EXHIBIT A-1

Older Americans Act FY2008 Federal Appropriations, by Title

Title*		Amount
Title II	Aging Network Support Activities	$49.7 million
Title III	Grants for State & Community Programs on Aging	$1,283.8 million
Title IV	Research, Training, and Demonstrations	$14.7 million
Title V	Community Service Employment for Older Americans	$521.6 million
Title VI	Grants for Native Americans	$33.2 million
Title VII	Vulnerable Elder Rights Protection Activities	$20.6 million
Total		**$1.924 billion**

SOURCE: National Health Policy Forum-George Washington University, *The Aging Services Network: Accomplishments and Challenges in Serving a Growing Elderly Population*, 2008.

*Title I involves no funding.

In general, the Administration on Aging distributes the funds according to formulas based on each state's proportionate share of the aging population. States allocate Older Americans Act funds to area agencies on aging based on formulas that may include population, income, and other relevant demographic factors.[13]

Title III is by far the single largest appropriation and provides funding for home and community-based support services, congregate and home-delivered nutrition services, preventive health services, and family caregiver support services. In 2008 Michigan is scheduled to receive $43.5 million, or 3.4 percent of the total funding for Title III.

[12] National Health Policy Forum—George Washington University, op. cit., 21.
[13] Ibid., 8.

State Appropriations History

20-Year History

Exhibit A-2 provides a 20-year appropriations history for the community and nutrition services program administered by Michigan's Office of Services to the Aging. For the most part, these are the programs funded at the federal level by the Older Americans Act and at the state level by the Older Michiganians Act. Not included in this table is funding for the HCBS waiver or the administrative costs of the OSA. The AAAs receive more than $83 million of the $88 million appropriated in 2008. The remaining funds are allocated to other human service agencies and advocacy organizations across the state.

EXHIBIT A-2

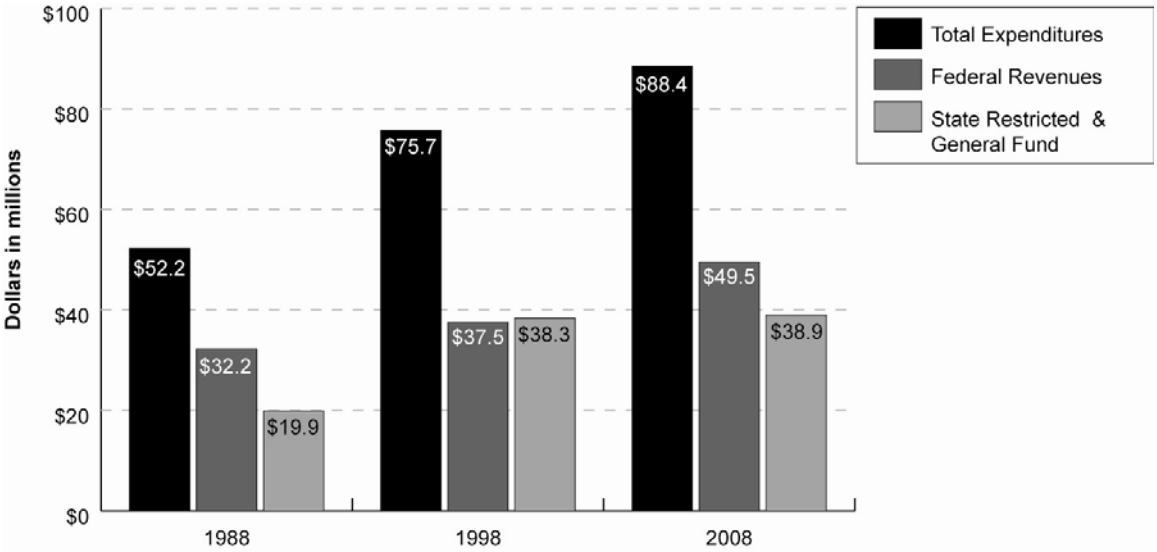
Community and Nutrition Services Appropriation, FY 1988–2008, Excluding HCBS Waiver

	1988	1993	1998	2003	2008	% Increase 20 Years	% Increase 10 Years
EXPENDITURES							
Community Services	$16,850,500	$17,484,100	$24,163,400	$34,589,900	$35,204,200		
Nutrition Services	26,207,800	28,564,500	35,164,500	37,289,300	37,922,500		
Senior Volunteer	3,933,300	3,857,900	4,130,900	5,970,000	5,624,900		
Employment Assistance	2,275,900	2,617,300	2,632,700	2,818,300	2,818,300		
Respite	—	600,000	3,500,000	7,100,000	6,800,000		
Michigan Pharmaceutical	—	2,500,000	5,000,000	—	—		
Sr. Staffing and Equipment	1,475,000	1,140,700	1,140,700	1,130,000	—		
Other	1,413,800	1,000	—	—	—		
Total Expenditures	**$52,156,300**	**$56,765,500**	**$75,732,200**	**$88,897,500**	**$88,369,900**	**69.4%**	**16.7%**
REVENUES							
Federal	$32,245,100	$36,684,940	$37,464,700	$46,679,800	$49,511,400	53.5%	32.2%
State Restricted	—	3,225,000	8,625,000	7,600,000	7,099,000	—	—
General Fund	19,911,200	16,855,560	29,642,500	34,617,700	31,759,500	59.5	7.1
Total Revenues	**$52,156,300**	**$56,765,500**	**$75,732,200**	**$88,897,500**	**$88,369,900**	**69.4%**	**16.7%**
Detroit CPI	114.8	138.6	158.9	182.0	209.7	82.7%	32.0%

SOURCES: 1988, PA 131 of 1987; 1993, PA 175 of 1992; 1998, PA 94 of 1997; 2003, PA 519 of 2002 & MDCH report, *Detailed Sources of Current Year Revenues*; February 2003; 2008, PA 123 of 2007 & MDCH report, *Detailed Sources of Current Year Revenues,* February 2008.

Over the 20-year period, spending increased by $36 million, or 69 percent. Federal support increased by $17 million, or 53 percent. General Fund support increased by $12 million, or 59 percent. During the same period the Detroit Consumer Price Index (CPI) increased by 83 percent (see Exhibit A-3).

EXHIBIT A-3
Community and Nutrition Services Appropriations, FY 1988, 1998, and 2008, Excluding HCBS Waiver



SOURCES: 1988, PA 131 of 1987; 1998, PA 94 of 1997; 2008, PA 123 of 2007 & MDCH report, *Detailed Sources of Current Year Revenues,* February 2008.

For the ten-year time period 1998 thru 2008, General Fund support increased by only $2.1 million or 7 percent. The CPI increased by 32 percent but overall spending increased by only 17 percent. Federal funding increased by $12 million, or 32 percent.

Overall Revenues and Expenditures

The MDCH recently issued a report that summarized the overall revenue and expenditures for each of the AAAs for the fiscal year ending September 30, 2007. Exhibits A-4 and A-5 summarize the expenditures and revenues by program and agency. Overall agency expenditures and revenues totaled $196 million and $199 million, respectively, which includes the HCBS waiver that is overseen by the MSA (not the OSA). Of the $199 million in total revenues only $28 million, or 14 percent, is generated at the local level. Locally generated revenues would include local government appropriations, county millages dedicated for aging, private donations, fundraising, program income, interest income, and revenue used as in-kind match.

EXHIBIT A-4

Area Agencies on Aging Expenditures, by Program, FY 2007

Expenditures by Program	Detroit	Region-1B	Senior Alliance	Region 2	Region IIIA	Region 3B	Region 3-C	Region 4
Title III & State Admin	$459,060	$1,000,852	$420,774	$180,613	$122,296	$83,951	$94,796	$131,771
Home Delivered Meals	3,285,335	8,105,900	480,956	1,122,395	587,666	450,902	262,848	673,895
Congregate Meals	1,746,342	2,995,151	2,885,893	524,113	364,364	347,929	159,398	352,748
Case Mgt & Targeted Case Mgt	546,478	2,710,693	613,774	286,077	189,373	511,330	135,210	257,183
In Home Services	390,482	937,228	280,574	821,223	118,234	62,459	77,473	98,037
Respite Services	248,074	3,215,297	614,066	220,936	172,425	43,729	107,712	343,433
Alternative Care Services	459,257	1,099,607	337,043	526,715	102,510	75,030	42,249	117,768
LTC Ombudsman Services	91,626	103,806	54,915	32,158	83,241	2,437	4,000	25,557
All Other Community services	2,753,287	4,109,763	1,859,806	708,730	333,508	1,630,831	81,175	682,156
Title V DOL	891,508	—	183,798	286,951	—	—	—	119,065
Michigan Choice Elderly & Disabled Waiver	11,419,715	13,892,245	2,544,417	4,377,108	—	7,419,707	—	5,296,086
Medicare/Medicaid assistance program	69,293	—	—	—	—	—	—	—
LTC Connection Single Point of Entry	2,186,494	—	210,777	—	—	—	—	1,622,446
Nursing Facility Transition	672,081	—	—	—	—	—	—	—
Local Activities	198,071	—	—	—	—	—	—	—
Fund Raising	—	—	37,523	—	—	—	—	—
Senior Center & Building Operations	—	—	—	—	—	1,174,250	—	—
Grants	—	—	—	—	—	96,340	—	—
Foster Grandparent Program	—	—	—	—	—	—	—	431,445
Sr. Companion Program	—	—	—	—	—	—	—	113,980
Retired SR. Volunteer Program	—	—	—	—	—	—	—	—
Total Expenditures	**$25,417,103**	**$38,170,542**	**$10,524,316**	**$9,087,019**	**$2,073,617**	**$11,898,895**	**$964,861**	**$10,265,570**

Expenditures by Program	Valley Area	Region 6	Region 7	Western MI	Region 9	Region 10	UP	Senior Resources	Total
Title III & State Admin	$217,234	$140,754	$326,490	$411,677	$196,457	$193,751	$284,951	$157,149	**$4,422,576**
Home Delivered Meals	1,458,699	1,193,425	1,897,416	2,252,843	1,486,098	748,251	2,095,458	977,506	**27,079,593**
Congregate Meals	445,507	701,504	801,763	731,652	1,108,700	510,875	1,490,501	699,526	**15,865,966**
Case Mgt & Targeted Case Mgt	453,408	282,911	600,022	691,533	620,199	667,895	658,521	291,697	**9,516,304**
In Home Services	161,621	126,968	242,413	260,373	653,087	110,731	208,216	132,273	**4,681,392**
Respite Services	491,919	316,979	445,067	861,511	230,470	678,983	343,898	487,527	**8,822,026**
Alternative Care Services	$194,150	$125,797	$291,202	$311,406	$217,782	$132,038	$249,888	$158,896	**$4,441,338**
LTC Ombudsman Services	31,752	26,463	57,488	59,658	56,886	35,638	86,023	33,592	**785,240**
All Other Community services	760,512	454,447	1,526,095	7,712,128	449,346	219,025	1,139,817	958,001	**25,378,627**
Title V DOL	66,598	—	506,369	315,243	48,535	129,018	55,691	—	**2,602,776**
Michigan Choice Elderly & Disabled Waiver	3,405,321	7,379,682	5,044,201	6,419,338	2,712,964	2,926,334	7,074,700	5,249,065	**85,160,883**
Medicare/Medicaid assistance program	—	—	—	—	—	—	—	—	**69,293**
LTC Connection Single Point of Entry	—	—	—	—	—	—	—	313,139	**4,332,856**
Nursing Facility Transition	—	—	—	—	—	—	—	—	**672,081**
Local Activities	—	—	145,236	—	—	—	—	—	**343,307**
Fund Raising	—	—	—	—	—	—	—	—	**37,523**
Senior Center & Building Operations	—	—	—	—	—	—	—	—	**1,174,250**
Grants	—	—	—	—	—	—	—	—	**96,340**
Foster Grandparent Program	—	—	—	—	22,033	—	—	—	**453,478**
Sr. Companion Program	—	—	—	—	91,034	—	—	—	**205,014**
Retired SR. Volunteer Program	—	—	—	—	32,051	—	—	—	**32,051**
Total Expenditures	**$7,686,721**	**$10,748,930**	**$11,883,762**	**$20,027,362**	**$7,925,642**	**$6,352,539**	**$13,687,664**	**$9,458,371**	**$196,172,914**

SOURCE: MDCH, *Annual Expenditure Report for Area Agencies on Aging*, Section 1417, March 2008 (report required by MDCH 2008 appropriations bill).

EXHIBIT A-5
Area Agencies on Aging Revenues, by Program, FY 2007

Agency	Federal	State	Local	Private	Fund Raising	In-Kind Match	Program Income	Interest Income	Other	Total
Detroit	$12,164,537	$11,064,832	$367,164	$50,850	$225,463	$1,235,859	$361,372	$167,408	($123,257)	**$25,514,228**
Region I B	17,684,790	13,133,436	1,424,946	—	166,524	2,577,174	3,924,347	—	—	**38,911,217**
Senior Alliance	7,494,012	3,054,514	312,866	57,081	84,362	19,347	—	—	—	**11,022,182**
Region 2	4,061,735	3,016,585	1,227,008	5,529	—	257,668	661,845	52,009	—	**9,282,379**
Region IIIA Kalamazoo	871,383	708,981	11,014	28,464	—	134,142	319,632	—	—	**2,073,616**
Region 3B	1,142,878	8,698,825	856,938	539,605	16,739	—	13,009	528,231	—	**11,796,225**
Region 3C Branch--St Joe	518,386	413,900	24,000	—	—	10,437	—	—	—	**966,723**
Region 4	5,529,725	4,550,756	30,000	198,144	—	—	72,923	113,831	—	**10,495,379**
Valley Area Region	4,192,178	3,323,050	58,000	126,862	14,806	—	1,336	7,639	22,864	**7,746,735**
Region 6	9,154,958	890,165	46,346	—	142,370	67,276	447,815	—	—	**10,748,930**
Region VII	7,024,259	4,874,301	44,770	—	—	65,279	8,861	84,961	71,935	**12,174,366**
Western MI	10,986,363	3,567,764	5,522,333	131,721	—	90,954	251,344	—	—	**20,550,479**
NEMCSA Region 9	4,760,756	1,725,365	198,870	22,294	—	85,174	1,182,795	156	—	**7,975,410**
NW MI Region 10	4,680,023	1,441,152	34,855	—	—	81,986	114,523	—	—	**6,352,539**
UPCAP	6,560,214	5,238,106	—	—	—	534,082	1,316,983	38,279	—	**13,687,664**
Senior Resources Region 14	4,410,126	3,843,027	4,020	51,372	108,394	702,720	359,682	171,345	67,731	**9,718,417**
Total Revenues	**$101,236,323**	**$69,544,759**	**$10,163,130**	**$1,211,922**	**$758,658**	**$5,862,098**	**$9,036,467**	**$1,163,859**	**$39,273**	**$199,016,489**

SOURCE: MDCH, *Annual Expenditure Report for Area Agencies on Aging*, Section 1417, March 2008 (report required by MDCH 2008 appropriations bill).

Exhibit A-6 summarizes the overall revenues by agency, **excluding** the $86.6 million for the HCBS waiver. If those funds are excluded the total revenues are reduced to $112 million and the share of locally generated revenues increases to 25 percent. These revenues are summarized, by funding source, in Exhibit A-7.

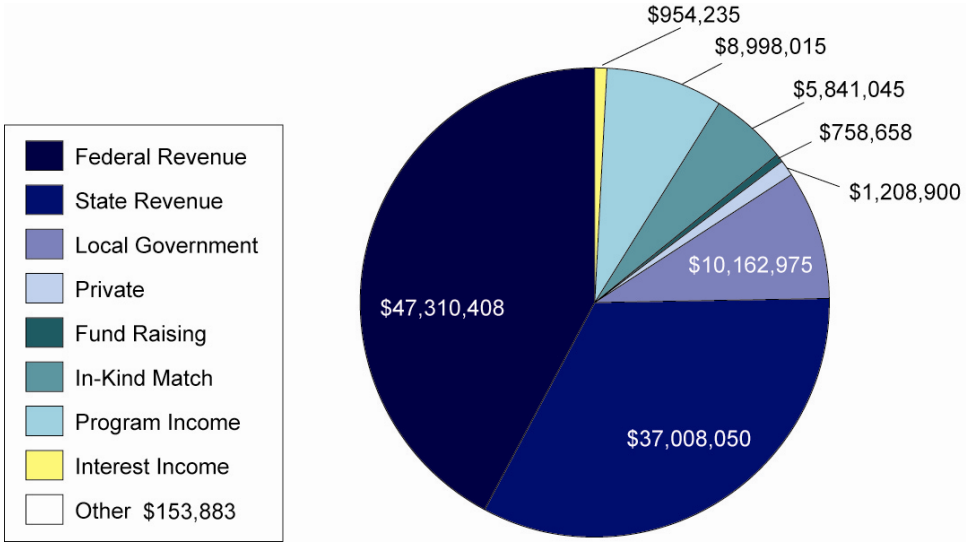
EXHIBIT A-6

Area Agencies on Aging Revenues, by Program, Excluding HCBS Waiver, FY 2007

Agency	Federal	State	Local	Private	Fund Raising	In-Kind Match	Program Income	Interest Income	Other	Total
Detroit	$5,837,104	$5,826,882	$367,164	$50,850	$225,463	$1,235,859	$361,372	$167,408	$18,411	**$14,090,513**
Region I B	9,823,169	7,102,812	1,424,946	—	166,524	2,577,174	3,924,347	—	—	**25,018,972**
Senior Alliance	4,592,977	3,054,514	312,866	57,081	84,362	19,347	—	—	—	**8,121,147**
Region 2	1,495,778	1,031,434	1,227,008	5,529	—	257,668	661,845	52,009	—	**4,731,271**
Region IIIA Kalamazoo	871,383	708,981	11,014	28,464	—	134,142	319,632	—	—	**2,073,616**
Region 3B	1,142,878	1,124,578	856,938	539,605	16,739	—	13,009	528,231	—	**4,221,978**
Region 3C Branch--St Joe	518,386	413,900	24,000	—	—	10,437	—	—	—	**966,723**
Region 4	2,482,834	2,213,496	30,000	198,144	—	—	72,923	113,831	—	**5,111,228**
Valley Area Region	2,289,403	1,821,325	58,000	126,862	14,806	—	515	7,639	22,864	**4,341,414**
Region 6	1,775,276	890,165	46,346	—	142,370	67,276	447,815	—	—	**3,369,248**
Region VII	4,053,685	2,553,475	44,615	—	—	65,279	8,861	84,961	71,935	**6,882,811**
Western MI	4,318,406	3,567,764	5,522,333	131,721	—	90,954	251,344	—	—	**13,882,522**
NEMCSA Region 9	2,068,259	1,704,898	198,870	22,294	—	85,174	1,182,795	156	—	**5,262,446**
NW MI Region 10	1,791,320	1,441,152	34,855	—	—	81,986	76,892	—	—	**3,426,205**
UPCAP	2,706,056	2,055,843	—	—	—	534,082	1,316,983	—	—	**6,612,964**
Senior Resources Region 14	1,543,494	1,496,831	4,020	48,350	108,394	681,667	359,682	—	40,673	**4,283,111**
Total Revenues	**$47,310,408**	**$37,008,050**	**$10,162,975**	**$1,208,900**	**$758,658**	**$5,841,045**	**$8,998,015**	**$954,235**	**$153,883**	**$112,396,169**

SOURCE: MDCH, *Annual Expenditure Report for Area Agencies on Aging*, Section 1417, March 2008 (report required by MDCH 2008 appropriations bill).

EXHIBIT A-7
Area Agencies on Aging Revenues, by Source, Excluding HCBS Waiver, FY 2007



SOURCE: MDCH, *Annual Expenditure Report for Area Agencies on Aging*, Section 1417, March 2008 (report required by MDCH 2008 appropriations bill).

Home and Community Based Services Waiver

Most of the AAAs provide care management services for the HCBS waiver population. In those instances the waiver costs flow through the local agency. The state's waiver program began with pilot projects in the early 1990s. In 1998 the program went statewide and the expenditures increased to $96 million. Expenditures hit an all-time high of $149 million in 2001. Budget reductions over the next few years reduced the appropriation to less than $100 million. By FY 2008 the appropriation was increased to $123 million.

Exhibit A-8 provides a 20-year revenue and expenditure history for the AAAs that includes funding for the HCBS waiver. Overall spending increased by 307 percent over the 20-year period and by 84 percent over the last ten years. Federal funding (including Medicaid) increased by 284 percent over the 20-year history and by 111 percent over the last ten years. State support increased by 344 percent over the 20-year history and by 57 percent over the last ten years. All of these increases far exceed the Detroit CPI increases of 83 percent over 20 years and 32 percent over the last ten years.

EXHIBIT A-8

20-Year State Appropriations History, Area Agencies on Aging Community & Nutrition Services and HCBS Waiver

						% Increase	
	1988	1993	1998	2003	2008	20 Years	10 Years
Expenditures							
Community Services	$16,850,500	$17,484,100	$24,163,400	$34,589,900	$35,204,200		
Nutrition Services	26,207,800	28,564,500	35,164,500	37,289,300	37,922,500		
Senior Volunteer	3,933,300	3,857,900	4,130,900	5,970,000	5,624,900		
Employment Assistance	2,275,900	2,617,300	2,632,700	2,818,300	2,818,300		
Respite	—	600,000	3,500,000	7,100,000	6,800,000		
Michigan Pharmaceutical	—	2,500,000	5,000,000	—	—		
Sr. Staffing and Equipment	1,475,000	1,140,700	1,140,700	1,130,000	—		
Other	1,413,800	1,000	—	—	—		
HCBS Waiver*	—	—	39,379,600	96,333,500	123,800,300		
Total Expenditures	**$52,156,300**	**$56,765,500**	**$115,111,800**	**$185,231,000**	**$212,170,200**	**306.8%**	**84.3%**
Revenues							
Federal	$32,245,100	$36,684,940	$37,464,700	$46,679,800	$49,511,400		
Medicaid	—	—	21,264,984	43,350,075	74,280,180		
State Restricted	—	3,225,000	8,625,000	7,600,000	7,099,000		
General Fund	19,911,200	16,855,560	47,757,116	87,601,125	81,279,620		
Total Revenues	**$52,156,300**	**$56,765,500**	**$115,111,800**	**$185,231,000**	**$212,170,200**	**306.8%**	**84.3%**
Detroit CPI	114.8	138.6	158.9	182.0	209.7	82.7	32.0
All Federal (Medicaid, AoA, and DOL)	32,245,100	36,684,940	58,729,684	90,029,875	123,791,580	283.9	110.8
State Support (GF and State Restricted)	19,911,200	20,080,560	56,382,116	95,201,125	88,378,620	343.9	56.7

SOURCES: 1988, PA 131 of 1987; 1993, PA 175 of 1992; 1998, PA 94 of 1997; 2003, PA 519 of 2002, MDCH report, *Detailed Sources of Current Year Revenue,* February 2003; 2008, PA 123 of 2007, MDCH report, *Detailed Sources of Current Year Revenue*, February 2008, and HCBS Waiver, State Budget Office, May 2008.
*HCBS Waiver: 1998 and 2003 represent actual expenditures, 2008 represents enacted budget.

MENTAL HEALTH OVERVIEW

The Mental Health and Substance Abuse Administration within the MDCH carries out the responsibilities specified in the state's Mental Health Code. The original 1974 code was extremely comprehensive but the highlight of the code was that it established the principle of placing individual recipients into the least restrictive setting and required the state to direct delivery of mental health services to the county programs as it was able. The Code was amended in 1995 to require an individual plan of service for all recipients. This latter requirement is implemented through what is referred to as a "person centered planning process."

Today mental health and developmentally disabled services are delivered through county-based CMHSPs. The MDCH contracts with 46 regional CMHSPs to provide an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. The MDCH also contracts with 18 PIHPs for the delivery of Medicaid-eligible services. The funds are distributed on a per-Medicaid-eligible capitated basis. The PIHPs are consolidated affiliations of the CMHSPs which were created to serve as a fiscal intermediary for the Medicaid waiver programs.

History

Mid-Nineteenth Century through Mid-Twentieth Century

In 1833 Massachusetts opened Worcester State Hospital, the first psychiatric asylum in the United States.[14] This was the beginning of what has been referred to as the "Institutional Era" in the delivery of public mental health services. In the mid-nineteenth century, state psychiatric asylums were considered enlightened, progressive, and humane. In 1859 Michigan opened its first institution, the Kalamazoo Asylum for the Insane. By the turn of the twentieth century similar facilities had been established in Pontiac, Traverse City, and Newberry.[15]

The 2004 Final Report issued by the Michigan Mental Health Commission provides an *Overview of Michigan's Public Mental Health System*. Appendix E of that report concisely describes the evolution of the Institutional Era as follows:

> For much of the 19th century, public asylums in America generally housed a relatively modest proportion of long-term or chronically incapacitated patients, and these facilities had not yet assumed the role of custodial care institutions… By the end of the 19th century, however, these circumstances had changed, precipitating a steady increase in the proportion of chronically disabled, elderly, and disordered individuals with underlying somatic conditions… This trend continued into the 20th century, and the average length of stay at public hospitals increased dramatically, with a concomitant decrease in discharge rates… Mental

[14] Mass.Gov website, Executive Office of Health & Human Services, Department of Mental Health, last updated 2008, *http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Mental+Health&sid=Eeohhs2&b=terminalcontent&f=dmh_g_about&csid=Eeohhs2*.

[15] Michigan Mental Health Commission Final Report, Appendix E: *Overview of Michigan's Public Mental Health System* (Lansing, Mich.: Michigan Mental Health Commission, October 15, 2004), 83.

> illness came to be regarded as a lifelong, gravely disabling malady with little prospect for recovery… This gloomy perspective, in turn diminished public support and legislative concern for state psychiatric facilities and hospitals steadily became more overcrowded, understaffed, regimented, bureaucratic, drab, and impoverished. By the mid-1950s there were more than 559,000 individuals in publicly operated psychiatric hospitals across the Unites States. In that same period over 20,000 Michiganians with mental illness were residing in state- or county-operated psychiatric facilities. [16]

1950s through 1990s

Scientific advances including the widespread use of antipsychotic drugs and the growing recognition of the adverse effects of prolonged institutional care led to a gradual decrease in census at these state-run institutions. In the 1950s and 1960s numerous commissions and studies began to explore ways to improve the system. Highlights of events that transformed the mental health system in the United States and in Michigan over the next 50 years are summarized below.

- 1946—The National Mental Health Act establishes the National Institute on Mental Health and authorizes grants to states to support existing outpatient clinics that served individuals with mental illness.
- 1953—The American Medical Association (AMA) and the American Psychiatric Association (APA) recommend a national study regarding the treatment of persons with mental illness.
- 1955—Based on the 1953 AMA and APA study, Congress adopts the Mental Health Study Act.
- 1961—The Joint Commission on Mental Illness and Health completes the study authorized in 1955. Its report, *Action for Mental Health*, recommends changes in archaic state hospital systems and suggests the development of local centers to address the needs of the mentally ill.
- 1963—President John Kennedy forms an interagency task force on mental illness to determine priorities for action and proposals for implementation.
- 1963—The Community Mental Health Centers Act is approved by Congress and signed by the president. The law provides funds for the development of community-based care centers.
- 1963—The Michigan Legislature passes Public Act 54, permitting counties either singly or in combination to form Community Mental Health Boards and allowing for matching funds at 40-60 percent. By 1969 there were 33 boards covering 49 counties.
- Between 1965 and 1975, the patient census at state hospitals fell from 17,000 to roughly 5,000.
- 1974—The legislature enacts the Mental Health Code, Public Act 254. This statute was a tipping point in the conversion from an institutional care system to a community-based treatment model. State match is increased to 90 percent.
- 1979—Governor William Milliken establishes the Committee on Unification of the Public Mental Health System. The committee report recommends the establishment

[16] Michigan Mental Health Commission, *Overview*, 83.

of single points of entry at the community level. The Michigan Department of Mental Health develops the "full management" concept, where placement decisions are made at the local level and the dollars follow the patient.

- 1990—The state obtains approval for its Home and Community Based Services Waiver (HCBS).
- 1995—Amendments to the Mental Health Code are enacted.
- 1998—The state obtains approval for a joint Home and Community Based Services Waiver and a Medicaid Freedom of Choice Waiver.[17]

Waivers

With the approval of the waivers in the 1990s the state mental health system began to rely more and more on Medicaid as a funding source for mental health services. The first waiver obtained by the state was the Home and Community Based Services Waiver under section 1915(c) of the Social Security Act. This waiver allows individuals who meet the criteria for long-term institutional care to receive services delivered in community settings and still retain Medicaid eligibility. In this case the practical effect was to encourage the placement of the developmentally disabled population into community settings as opposed to more costly state-run institutions.

In 1998 the state was granted a combined 1915(c) and 1915(b) waiver. The 1915(b) waiver, otherwise known as a Medicaid Freedom of Choice Waiver, permitted the state to implement a capitated managed care program for specialty mental health services through the Community Mental Health Services Programs. The capitated payment system would carve out specialty mental health, substance abuse, and developmental disabilities services and provide these services under a prepaid shared risk arrangement.

Statutory Mandates and Governance Structure

The CMHSPs continue to operate under the 1974 provisions of the Mental Health Code. The 1974 statute embraced the trend of moving toward community-based services by designating priority populations for service and core program requirements, establishing the principle of least restrictive setting for care and treatment decisions, specifying the rights of service recipients, and devising a monitoring and protections system.[18]

The CMHSPs must also comply with major revisions to the code that were enacted in 1995. These provisions included: the establishment of a new, more independent type of CMHSP entity, known as an authority; a requirement that each board be certified by a nationally recognized accreditation organization; and a requirement that the individual plan of service for all recipients of the public mental health system be developed through a "person-centered" planning process. The 1995 amendments also added an incentive for CMHSPs to become an authority, by reducing the county match from 10 to 5 percent.

Today 46 CMHSPs ensure that a comprehensive range of mental health services is provided in all 83 Michigan counties. Forty CMHSPs have adopted the authority

[17] Michigan Mental Health Commission, *Overview*, 84–88, 90–92.
[18] Ibid., 87.

structure, five continue to remain agencies of county government, and one is formed under the Urban Cooperation Act.

A 12-member board of directors governs each CMHSP locally. In the case of a single county board, the county board of commissioners appoints all of the members. In the case of a multi-county CMHSP, the board member appointments are divided proportionally based on populations, except that each county must have at least one member. The Detroit Wayne Board consists of six members appointed by the mayor of the City of Detroit and six members appointed by the Wayne County executive. The county executive appointments are subject to the approval of the Wayne County Board of Commissioners.[19]

In addition to the state's statutory requirements, the CMHSPs must also comply with all of the requirements of the federal waivers. The second phase of the specialty services waiver required that the state could only procure services from a PIHP that had at least 20,000 Medicaid beneficiaries in its service plans. The result was the consolidation of the 46 CMHSPs into 18 PIHPs for the purposes of managing the waiver dollars. Of the 18 PIHPs, ten are formed by affiliations of CMHSPs, and eight are individual CMHSPs.

Other States' Governance and Funding Structures

The organizational structure of behavioral health services among the states varies widely. Some states are like Michigan and house mental illness, substance abuse, and developmentally disabled services in a larger department of community health or health and human services. Other states may place them in a separate "stand-alone" department. Another alternative is the placement of developmental disability programs as a division within a department or bureau on long-term care.

A common theme among the states over the last two decades is the increased reliance on Medicaid as a funding source. In order to maximize these federal resources most states have opted to take advantage of the Home and Community Based Services waiver. According to the Centers for Medicare and Medicaid Services (CMS) website, 48 states and the District of Columbia offer more than 287 active HCBS programs. Michigan and Texas are the only two states that operate joint 1915(b) and (c) waivers. Texas' waiver, however, covers the elderly and disabled populations,[20] while Michigan's joint waver is limited to behavioral health services.

Mental Health Spending

In terms of comparing Michigan's spending to other states, most national studies report separately for mental health and developmental disabilities. A recently released study by the State Mental Health Association (SMHA) provides state-by-state revenue and expenditure data from 1981 through 2005. This study includes mental health spending in both community and hospital settings. In fiscal year (FY) 2005 Michigan's per capita expenditures were $96.40 as compared to the U.S. average of $103.43 (see Exhibit A-9).

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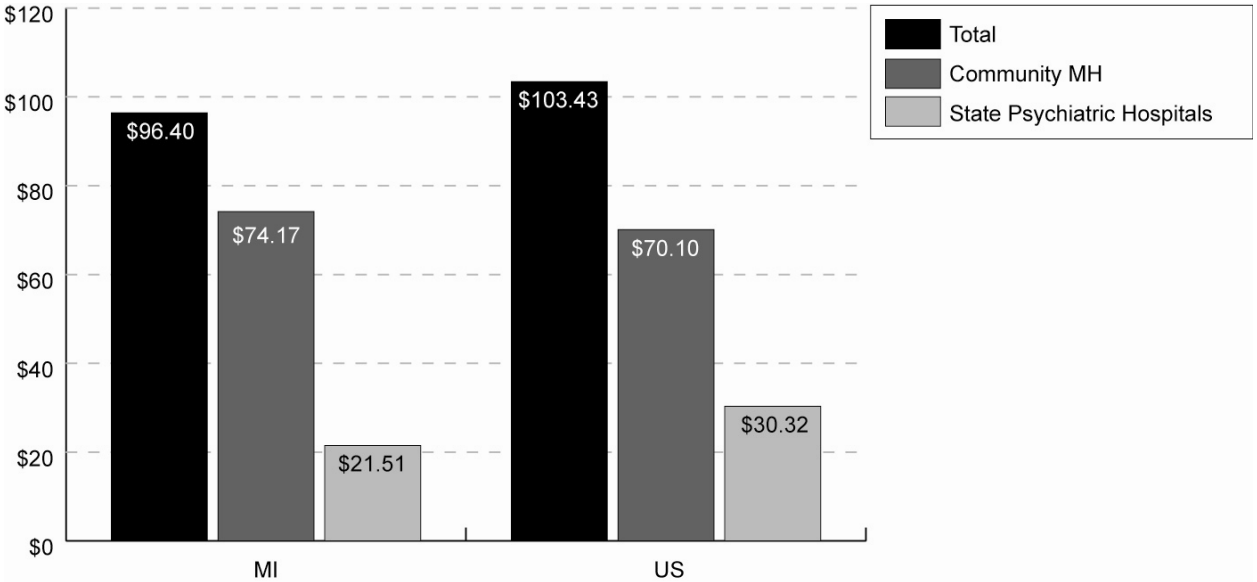
[19] Michigan Mental Health Code, Act 258 of 1974 as amended, MCL 330.1214-1216.

[20] U.S. Department of Health and Human Services website, Center for Medicare and Medicaid Services, May 2008. Online, available: *http://www.cms.hhs.gov/MedicaidSPtWaivProgDemoPGI*.

Medicaid (state and federal) accounted for 42 percent of mental health revenues nationally, compared to 62 percent in Michigan.

EXHIBIT A-9
Michigan and U.S. Per Capita Mental Health Spending, FY 2005



SOURCE: National Association of State Mental Health Program Directors, National Research Institute Inc., Revenue and Expenditure Data: 1997–2005, November 2007.

In 1981 Michigan spent $32.49 per capita, compared to the national average of $24.20. In 2005 Michigan's inflation-adjusted per capita spending was $24.70, compared to the national average of $26.55. Overall, inflation adjusted per capita spending among the states ranged from $6.20 in New Mexico to $69.20 in Alaska. The overall median was $22.90.[21]

Developmental Disabilities Spending

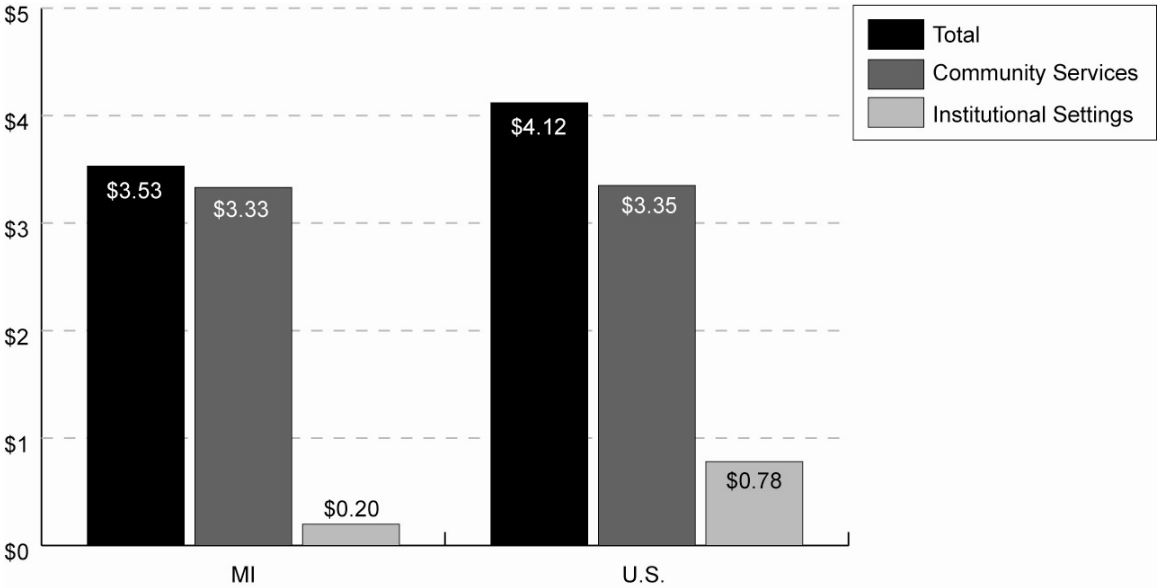
Every few years the Coleman Institute for Cognitive Disabilities at the University of Colorado updates a study entitled, *The State of the States in Developmental Disabilities*. The most recent update was published earlier this year. This ongoing national study evaluates trends in the delivery of services and funding for "intellectual and developmental disabilities" (I/DD).

One of the key spending measurements in the study is fiscal effort, defined as a state's spending for I/DD services per $1,000 of total state personal income. In 2006 Michigan ranked 36th in overall fiscal effort, 28th in community services, and 39th in institutional spending. In 1977 Michigan's per capita fiscal effort was $1.98, compared to the overall national per capita effort of $2.24. In 2006 Michigan's per capita fiscal effort had

[21] National Association of State Mental Health Program Directors, National Research Institute Inc., *Revenue and Expenditure Data: 1997 to 2005 (Alexandria, Va.:* November 2007). Online, available: *http://www.nri-inc.org/reports%5Fpubs/pub_list.cfm?getby=Revenues%20and%20Expenditures*.

increased to $3.53, compared to the overall national per capita effort of $4.12 (see Exhibit A-10).

EXHIBIT A-10
Michigan and U.S. Per Capita I/DD Fiscal Effort, FY 2006



SOURCE: Braddock et al., *The State of the State in Developmental Disabilities, 2008*.

Michigan's total spending on I/DD in 2006 was $1.2 billion. Across the nation federal dollars accounted for 54 percent of total revenues, compared to 58 percent in Michigan. In Michigan, state and local revenues accounted for 41.5 and 0.5 percent of total revenues, respectively. Nationally, state and local revenues account for 42 and 4 percent of total revenues, respectively.[22]

It appears that Michigan's spending on mental health and developmental disability services is slightly lower than the national average. Our spending on community services appears to be near that of other states. For instance, Michigan's per capita fiscal effort for the I/DD population is $3.33, compared to overall U.S. per capita spending of $3.35. Conversely, our spending on institutional services appears to be well below the national average. It also appears as if Michigan has done a much better job of maximizing federal revenues through the various Medicaid waiver programs.

Funding History

20-Year History

Exhibit A-11 provides a 20-year history in five-year increments of state appropriations for CMHSP programs. The 20-year history is based on the originally enacted state

[22] Braddock et al., *The State of the State in Developmental Disabilities 2008* (Boulder, Colo.: Department of Psychiatry and Coleman Institute for Cognitive Disabilities, University of Colorado, 2008), 190–193, 306–309.

appropriation bill for each fiscal year. The CMHSP programs in the funding history include residential services programs still operated by the state into the early 1990s, Medicaid programs, the federal mental health block grant, the General Fund appropriation that is allocated to each CMHSP for non-Medicaid programs, and the purchase of service dollars that are allocated to each CMHSP to reimburse the state for psychiatric hospital beds. Also included in separate subtotals are the appropriations for state-run psychiatric hospitals, excluding the two forensic centers. Not included are appropriations for MDCH's administrative costs, special projects, Omnibus Reconciliation Act, or family support subsidy.

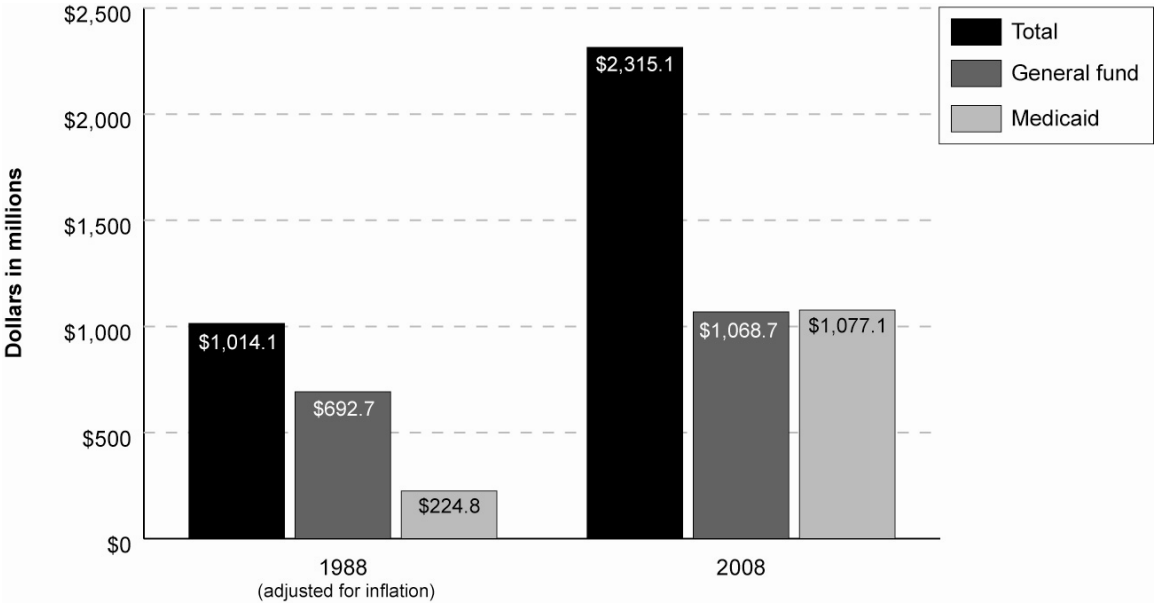
EXHIBIT A-11
CMHSP Appropriations, FY 1988–2008

	1988	1993	1998	2003	2008	% Change 20 yrs.	% Change 10 yrs.
CMHSPs Appropriations							
CMHSP Programs	$325.1	$582.8	$1,180.0	—	—		
Medicaid	—	—	—	1,333.7	1,777.5		
CMHSP non-Medicaid	—	—	—	276.9	319.6		
Residential Services	256.1	260.7	—	—	—		
Federal Mental Health Block Grant	5.3	5.3	10.8	15.3	15.4		
Purchase of Service (POS)	380.8	349.0	202.2	165.8	136.2		
Subtotal CMHSP Expenditures	967.3	1,197.8	1,393.0	1,791.7	2,248.7	132.5%	61.4%
Psychiatric Hospitals without Forensics	427.6	320.0	322.6	227.8	202.6	(52.6)	(37.2)
Total Expenditures	**$1,394.9**	**$1,517.8**	**$1,715.6**	**$2,019.5**	**$2,451.3**	**75.7%**	**42.9%**
Totals without POS	$1,014.1	$1,168.8	$1,513.4	$1,853.7	$2,315.1	128.3%	53.0%
Major Funding Sources							
General Fund	$692.7	$824.5	$986.9	$976.5	$1,068.7	54.3%	8.3%
Medicaid Title XIX and SCHIP	224.8	254.3	477.5	834.5	1,077.1	379.1	125.6
Other Federal	5.3	6.9	10.8	15.6	15.6		
Local	39.9	34.0	19.8	15.1	39.1		
Other	51.4	49.1	18.4	12.0	114.6		
Total Funding Sources	**$1,014.1**	**$1,168.8**	**$1,513.4**	**$1,853.7**	**$2,315.1**	**128.3%**	**53.0%**
Detroit CPI	114.8	138.6	158.9	182	209.7	82.7	32.0

SOURCES: 1988, PA132 of 1987; 1993, PA 167 of 1992; 1998, PA 94 of 1997; 2003, PA 519 of 2002 & MDCH report; *Detailed Sources of Current Year Revenue*, February 2003; 2008, PA 123 of 2007 & MDCH report, *Detailed Sources of Current Year Revenue*, February 2008.

From 1988 to 2008, overall appropriations for CMHSP programs increased from $1 billion to $2.3 billion, or 128 percent (see Exhibit A-12). General Fund dollars increased from $693 million to $1.07 billion, or 54 percent. Federal Medicaid dollars increased from $225 million to $1.08 billion or 379 percent. These increases compare to the 83 percent increase in the Detroit CPI over that same 20-year period.

EXHIBIT A-12
CMHSP State Appropriations, FY 1988 and FY 2008

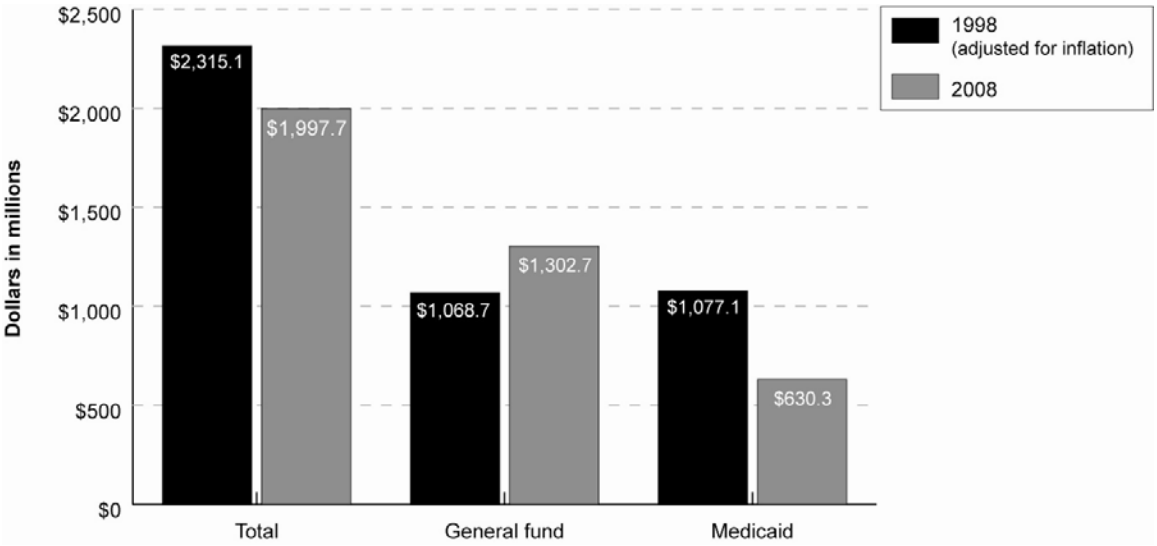


SOURCES: 1988, PA132 of 1987; 1993, PA 167 of 1992; 2008, PA 123 of 2007 & MDCH report, *Detailed Sources of Current Year Revenue*, February 2008.

Over the last ten years appropriations increased by 61 percent compared to a CPI increase of only 32 percent. The comparisons vary only slightly if funding for state psychiatric hospitals is included and purchase of service dollars is excluded. The purchase of service dollars should be excluded from any total expenditure comparison to avoid double counting (i.e., as an appropriation to the boards and a revenue to the hospitals).

The increases in funding sources vary greatly in terms of a comparison to the CPI. For instance, federal Medicaid dollars increased by 126 percent over the last ten years and General Fund dollars by only 8 percent. Put another way, over the last ten years, if General Fund dollars had increased at the rate of inflation, the 2008 appropriation would be $1.3 billion as opposed to the actual appropriation of $1.1 billion. Medicaid funding, on the other hand, would have increased to only $630 million, as opposed to the actual 2008 appropriation of $1.1 billion (see Exhibit A-13).

EXHIBIT A-13
CMHSP State Appropriations, FY 1998 and FY2008



SOURCES: 1998, PA 94 of 1997; 2008, PA 123 of 2007 & MDCH report, *Detailed Sources of Current Year Revenue*, February 2008

The appropriations are consistent with the trends discussed earlier in terms of the transition from institutional placements to community-based care. The good news is that the state has maximized federal dollars. The caution is that as General Fund support as a share of total spending declines, the local boards may find it increasingly difficult to provide service to the non-Medicaid-eligible mentally ill population.

Overall Expenditures

Each CMHSP provides the MDCH with annual information related to their overall expenditures. The information is consolidated into a boilerplate report that is submitted to the legislature. The MDCH "boilerplate" report includes information on each CMHSP's per capita costs for each program. The average per capita cost for adults with mental illness was $99.20. The per capita costs ranged from a high of $151 in Detroit-Wayne to

a low of $42 in Barry County. The average per capita costs for persons with developmental disabilities was $93.37. These costs ranged from a high of $245 in Sanilac County to a low of $36 in Barry County.[23]

The national studies on I/DD and mental health spending cited previously indicate that the CMHSPs operate with very little local support. The national I/DD study indicated that local funding accounted for only $5.9 million of the $1.2 billion spent on developmental disability services in Michigan in 2006. The SMHA study indicated that in 2005, local funding for mental health services accounted for $21.8 million, or 2 percent of overall spending of $973.5 million. In essence, the CMHSPs have become a Medicaid system funded almost entirely with federal and state dollars.

SUBSTANCE ABUSE COORDINATING AGENCIES OVERVIEW

The Public Health Code assigns the duties and responsibilities for substance abuse treatment and prevention to the Office of Drug Control Policy (ODCP) within the MDCH. In order to fulfill these duties the Code in turn authorizes the ODCP to contract with designated regional coordinating agencies. Today there are 16 regional coordinating agencies that contract with and receive funding from the ODCP. The responsibilities of the 16 agencies include the development of comprehensive regional plans for treatment, rehabilitation, and prevention services; technical assistance for local providers and organizations; data collection; evaluation and assessment of regional services; and the development and monitoring of contracts with local providers. The primary responsibility of the coordinating agencies is to contract with local providers for treatment services to clients that include detoxification, inpatient and outpatient care, short- and long-term residential therapy, and access services for women and families.

History

Federal

On New Year's Eve of 1970 President Nixon signed into law the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act. The law was more commonly referred to as the Hughes Act, in recognition of its congressional sponsor, Senator Harold E. Hughes (D-Iowa). Highlights of the new act were the creation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA); the appropriation of federal funds to the states to evaluate, plan, and coordinate substance abuse prevention and treatment programs; and authorization for grants and contracts for demonstration projects that provide treatment services.[24]

The Hughes Act came to be known as alcoholism's Magna Carta.[25] The events that led up to this landmark legislation are described below.

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[23] Section 404-MDCHreport required by the 2007 DCH appropriations bill, Subsection 404(2)(b), Per Capita Expenditures FY2006, May 2007.
[24] Brenda Hewitt, NIAAA, The Creation of the National Institute on Alcohol Abuse, *Alcohol Health and Research World* 19 (No. 1, 1995). Online, available: *http://www.niaaa.nih.gov/AboutNIAAA/OrganizationalInformation/history.htm*.
[25] Hewitt, op. cit., 3.

- 1935—Alcoholics Anonymous is founded.
- Mid 1930s—Research Council on Problems of Alcohol at Yale University is established.
- 1940—First publication of the *Quarterly Journal of Studies on Alcohol*.
- 1944—National Committee for Education and Alcohol (later called the National Council on Alcoholism) is founded.
- 1950s—The American Medical Association (AMA) and World Health Organization (WHO) begin to address the health care aspects of alcoholism and discrimination.
- 1960s—The American Psychiatric Association and American Public Health Association join with AMA and WHO in declaring alcoholism an illness.
- 1969—Senator Harold Hughes, a freshman Senator from Iowa and a recovering alcoholic, is appointed chair of the Special Senate Subcommittee on Alcoholism and Narcotics. The subcommittee holds hearings across the country. After the hearings Senator Hughes introduces S. 3835, a bill intended to provide a comprehensive federal program that would address the prevention and treatment of alcohol abuse and alcoholism.[26]

Michigan

Passage of the Hughes Act created federal funding for substance abuse programs and prompted Michigan to review and update its laws. That statutory history is summarized below.

- 1965—A legislative act reduces the number of principal state agencies from 120 to 19. As a part of this organization, a new Department of Public Health is created incorporating most of the functions of the former State Health Commissioner, Crippled Children's Commission, Board of Alcoholism, and Veteran's Facility.
- 1968—A new alcoholism information and counseling center opens in Marquette County, bringing the total number of centers in the state to nine.[27]
- 1968—Public Act 22 is enacted into law. The bill creates an alcoholism program within the Department of Public Health. The department's director, with the advice and counsel of the State Advisory Board on Alcoholism, is authorized to develop and carry out programs concerned with education and prevention of alcoholism.[28]
- 1970—A comprehensive alcoholism program is developed for expanding local programs into comprehensive alcoholism complexes centered in county health departments.
- 1971—Public Act 197 creates a temporary two-year agency on drug abuse and alcoholism problems within the Governor's Office. The act establishes an advisory commission on drug abuse and alcoholism policies.[29]
- 1973—A series of nine conferences are conducted throughout the state by the Department of Public Health and the Governor's Office of Drug Abuse and

[26] Hewitt, op. cit., 2.
[27] Michigan Department of Community Health, *The First 100 Years* (Lansing, Mich.: MDCH, 1973), 76.
[28] Ibid., 76.
[29] Public Act 197 of 1971.

Alcoholism to assist labor and management in developing occupational programs for combating alcoholism and drug abuse.[30]

- 1973—The legislature enacts Public Act 56, the Substance Abuse Services Act. The new law repeals Public Act 22 of 1968 and Public Act 197 of 1971 and establishes the Office of Substance Abuse Services within the Department of Public Health. In addition to all of the licensing and inspection requirements, the act authorizes the creation of regional substance abuse coordinating agencies.[31]
- 1978—Substance abuse statutory requirements are incorporated into the Public Health Code.

Statutory Mandates and Governance Structure

Part 62 of the 1978 Public Health Code as amended clearly defines the duties and responsibilities of the Office of Substance Abuse Services, the administrator of the office, the Advisory Commission on Substance Abuse Services, and the coordinating agencies. Originally an autonomous agency within the then Department of Public Health, the office was later moved into the Department of Community Health and today is known as the ODCP.

The process used to designate coordinating agencies is described in Section 6226 of the Public Health Code. The code provides that the director of the ODCP shall designate city, county, or regional coordinating agencies. The affected county board of commissioners must approve their participation in a regional coordinating agency. A city that has its own local health department (i.e., Detroit) may create a city or city-county regional coordinating agency. The code also allows a CMHSP, a local public health agency, or a public private nonprofit human services agency to be designated as a coordinating agency.

The general duties of a coordinating agency are defined in Section 6228 of the code as follows:

(a) Develop comprehensive plans for substance abuse treatment and rehabilitation services and prevention services consistent with guidelines established by the office.
(b) Review and comment to the office on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations.
(c) Provide technical assistance for local substance abuse service organizations.
(d) Collect and transfer data and financial information from local organizations to the office.
(e) Submit an annual budget request to the office for use of state administered funds for its city, county, or region for substance abuse treatment and rehabilitation services and prevention services in accordance with guidelines established by the administrator.
(f) Make contracts necessary and incidental to the performance of the agency's functions. The contracts may be made with public or private agencies,

[30] MDCH, *The First 100 Years*, 76.
[31] Public Act 56 of 1973.

organizations, associations, and individuals to provide for substance abuse treatment and rehabilitation services and prevention services.

(g) Annually evaluate and assess substance abuse services in the city, county, or region in accordance with guidelines established by the administrator.[32]

Today there are 16 substance abuse coordinating agencies. Among these there are ten multi-county agencies, five single-county agencies, and one city agency. Three of the agencies are part of the local health department (Detroit, Oakland, and Saginaw). Eight of the agencies are part of a CMHSP. In addition, since the coordinating agencies are a part of the 1998 specialty services waiver discussed in the mental health overview, each one of them has affiliated with one of the 18 prepaid inpatient health plans (PIHPs).

Other States' Governance and Funding Structures

Over the years federal substance abuse programs and services have experienced numerous name changes and organizational transformations. Today, these programs are administered at the federal level by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS). Within SAMSHA, substance abuse services are delivered by two different centers. The Center for Substance Abuse Prevention works with states and communities to develop comprehensive prevention systems that create healthy communities. Additionally, the Center for Substance Abuse Treatment works with states and community-based groups to improve and expand existing substance abuse treatment services.

Like their federal counterpart most states operationally locate their substance abuse programs in a larger department of community health or health and human services. These substance abuse programs are also commonly co-located in a bureau or agency with mental health administration. The local delivery networks are often very similar to Michigan's in that a local agency coordinates or contracts with providers for the actual delivery of services. Some states contract directly with providers and do not utilize a local network.

SAMHSA Study

In 2007 SAMHSA released a study that examined national trends in spending for mental health services and substance abuse treatment over a ten-year period, 1993 to 2003. Key findings for substance abuse treatment spending include the following:

- In 2003, an estimated $21 billion was devoted to treatment of substance abuse disorders. This amount constituted 1.3 percent of all health care spending.
- Public payments supported the majority of substance abuse expenditures. Throughout the 1993–2003 period, public expenditures continued to increase as a share of substance abuse expenditures, rising from 68 percent of substance abuse expenditures in 1993 to 77 percent in 2003.

[32] Public Act of 1978, Section 6228.

- Private insurance payments on substance abuse treatment grew at an average rate of 0.1 percent annually between 1993 and 2003, compared with the private payment annual growth rate for all health care of 7.3 percent.
- Non-Medicare and Medicaid federal government spending made up 17 percent of substance abuse expenditures in 1993 and only 15 percent in 2003. Non-Medicaid state and local government spending increased from 31 percent to 40 percent of substance abuse spending over the same time span, making it the largest financer of substance abuse treatment. Medicaid's share increased from 16 percent to 18 percent of substance abuse expenditures nationally, while the Medicare spending share (4 percent in 1993 and 4 percent in 2003) remained relatively constant.[33]

Overall funding for substance abuse treatment increased by $5.7 billion, or 37 percent. Funding by public payers (excluding Medicare) increased from $9.6 billion in 1993 to $15.1 billion in 2003, a 57 percent increase.[34] During the same period, state appropriations in Michigan for treatment and prevention services increased from $83.8 million to $114.9 million, an increase of $31 million, or 37 percent. (Please note that this is not an exact comparison between national trends and Michigan, because the only data available for Michigan is the combined prevention and treatment amounts.)

National Center on Addiction and Substance Abuse Study

In 2001 the National Center on Addiction and Substance Abuse at Columbia University published a study that examined the impact of substance abuse on the budgets of state governments. The study found that in 1998,

> states spent $620 billion of their own funds to operate state government and provide public services such as education, Medicaid, child welfare, mental health, and highway safety. A stunning 13.1 percent of that amount—$81.3 billion—went to shoveling up the wreckage of addiction, a problem that too many of us prefer to deny or ignore.[35]

The study provides spending information on the impact of substance abuse on each state's budget, as well as total state spending on prevention services. The study found that states spent $299 per capita on programs that bear the burden of substance abuse and only $11 per capita on prevention, treatment, and research. Michigan was ranked 13th, at $282 per capita, on the impact of substance abuse on a state's budget. Michigan was ranked 45th out of 47 that responded, at $0.19 per capita, on substance abuse prevention, treatment, and research spending.[36]

The $0.19 per capita amounts to only $1.8 million. Please refer to Exhibit A-14, which shows that in fiscal year (FY) 1998, the state General Fund appropriation for substance abuse was $32.2 million. That amount does not include funding in the departments of

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[33] U.S. Department of Health and Human Services, SAMHSA, *National Expenditures for Mental Health Services and Substance Abuse Treatment 1993-2003* (Washington, D.C.: DHHS, 2007), v.
[34] Ibid., 35.
[35] The National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets* (New York: NCASA, January 2001), 1.
[36] The National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up*, 25 and 30.

Corrections or Human Services that would have also been spent on substance abuse treatment. Although the overall Columbia study highlights important information for public policy makers in terms of the impact of substance abuse on state budgets, its usefulness in comparing Michigan to other states is problematic, given the inaccuracies in spending figures seen above. In preparing this report the authors have found that several recent publications continue to cite this study, and Michigan's 45th place ranking.

Funding History

State Appropriations

Exhibits A-14 and A-15 provide a 20-year history of state expenditures and revenues for substance abuse coordinating agencies. In Exhibit A-14, the 20-year period is broken down into 5-year increments. The table includes appropriations for prevention, education and treatment grants; state disability assistance program; Medicaid substance abuse program; and distributions from the Convention Facility Development Fund. It does not reflect appropriations for departmental administration of the program or the ODCP anti-drug abuse grants.

EXHIBIT A-14

State Appropriations for Substance Abuse, 1998–2008

						%Increase	
	1988	1993	1998	2003	2008	20 years	10 Years
Expenditures							
Prevention, Education, and Treatment Grants	$35,940,400	$62,629,100	$72,840,400	$76,335,400	$85,268,000		
State Disability Assistance Program for Substance Abuse	—	6,600,000	6,600,000	5,453,600	2,509,800		
Medicaid Substance Abuse	—	6,600,000	16,339,000	26,127,500	36,378,500		
Other Grants	8,804,500	6,769,300	11,002,000	—	—		
Convention Facility Development Fund*	—	1,210,008	5,099,039	7,003,975	9,209,383		
Total Expenditures	**$44,744,900**	**$83,808,408**	**$111,880,439**	**$114,920,475**	**$133,365,683**	**198.1%**	**19.2%**
Revenues							
Federal	$15,428,000	$50,927,900	$73,192,160	$72,224,700	$87,213,400	465.3%	19.2%
IDGs	2,809,600	—	—	—	—		
License Fees	1,360,000	1,360,000	1,360,000	1,460,000	1,784,200		
Other	120,000	—	—	—	—		
Quality Assessment Tax	—	—	—	—	2,000,800		
Convention Facility Development Fund	—	1,210,008	5,099,039	7,003,975	9,209,383		
General Fund	25,027,300	30,310,500	32,229,240	34,231,800	33,157,900	32.5	2.9
Total Revenues	**$44,744,900**	**$83,808,408**	**$111,880,439**	**$114,920,475**	**$133,365,683**	**198.1%**	**19.2%**
Detroit CPI	114.8	138.6	158.9	182.0	209.7	82.7%	32.0%

SOURCE: 1988, PA 130 of 1987; 1993, PA 166 of 1992; 1998, PA 94 of 1997; 2003, PA 519 0f 2002 and MDCH report, *Detailed Sources of Current Year Revenue*, February 2003; 2008, PA123 of 2007 and MDCH report, *Detailed Sources of Current Year Revenue*, February 2008.
*1993–2003 based on one half of actual distribution to each county.
NOTE: 2008 based on 06 dollars updated by inflation.

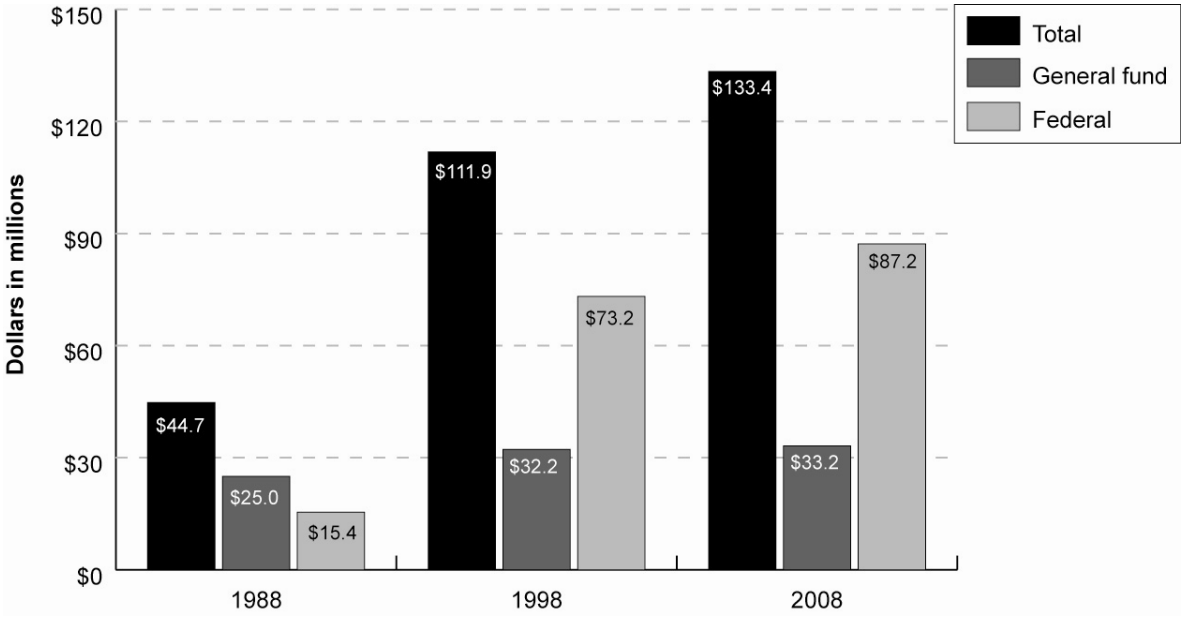
From 1988 to 2008, overall appropriations for substance abuse coordinating agencies in Michigan increased from $44.7 million to $133.4 million. This represents an increase of $88.6 million, or 198 percent, compared to an 83 percent increase in the Detroit CPI.

Federal funding increased by 465 percent over the 20-year period, but by only 19 percent over the last ten years (see Exhibit A-15). General Fund support increased by 32.5 percent over the 20-year period, and by 2.9 percent over the last ten years.

Over the last ten years, overall appropriations increased from $111.9 million to $133.4 million, an increase of $21.5 million, or 19.2 percent, compared to a 32 percent increase in the Detroit CPI.

EXHIBIT A-15

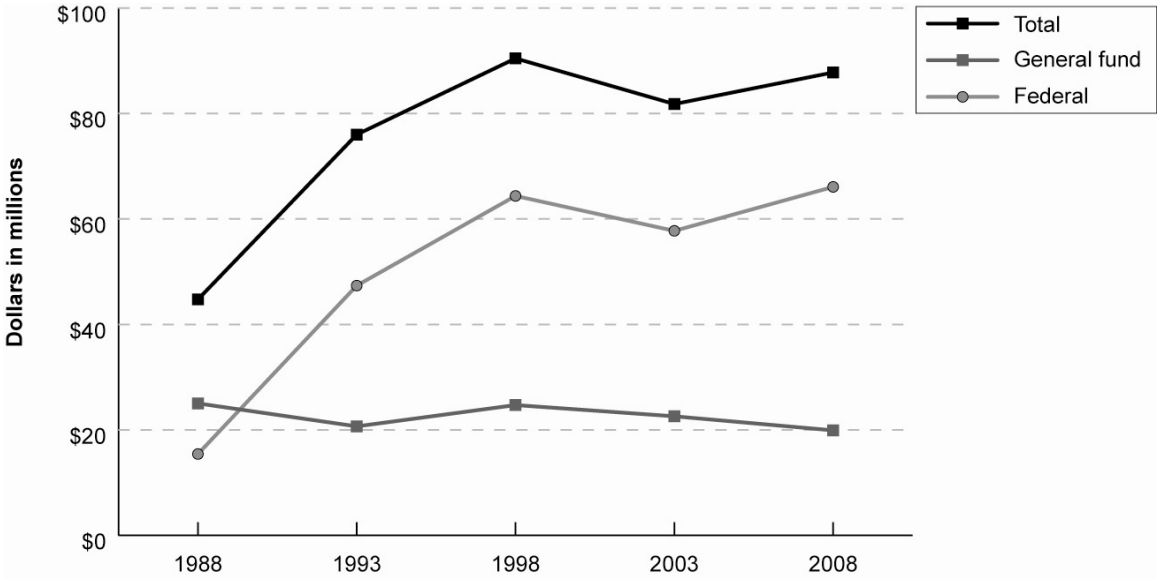
State Appropriations for Substance Abuse, 1988, 1998 and 2008



SOURCE: 1988, PA 130 of 1987; 1993, PA 166 of 1992; 1998, PA 94 of 1997; 2003, PA 519 0f 2002 and MDCH report, *Detailed Sources of Current Year Revenue*, February 2003; 2008, PA123 of 2007 and MDCH report, *Detailed Sources of Current Year Revenue*, February 2008.

Please note that the increases discussed above include General Fund support for the Medicaid substance abuse program. If the Medicaid dollars are excluded, the General Fund support actually decreased by $5.1 million over the 20-year period and $4.8 million over the last ten years (see Exhibit A-16).

EXHIBIT A-16
State Appropriations for Substance Abuse Minus Medicaid, FY 1988–2008



SOURCE: 1988, PA 130 of 1987; 1993, PA 166 of 1992; 1998, PA 94 of 1997; 2003, PA 519 0f 2002 and MDCH report, *Detailed Sources of Current Year Revenue*, February 2003; 2008, PA123 of 2007 and MDCH report, *Detailed Sources of Current Year Revenue*, February 2008

Significant Funding Changes

There have been three rather significant funding changes with regard to substance abuse over the last 30 years. The first was the passage of the Convention Facility Development Fund Act in 1985, which established a hotel/motel accommodations tax in Wayne, Oakland, and Macomb counties and increased the existing liquor tax. Proceeds were to be deposited in the Convention Facility Development Fund. These funds must first be used to cover the Cobo Hall debt service obligation. Any remainder is distributed to the counties according to a formula set in statute. If a county does not use the funds to lower its tax rate then it must distribute half of the payment to the local substance abuse coordinating agency. The first year of the distributions was 1986 and the coordinating agencies netted approximately $1.7 million. By 2006 the net proceeds had increased to $8.8 million.

The second significant change was in 1992 when President George H. W. Bush signed into law the Alcohol Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act. This law provided a significant increase in federal funding to the states for the ADAMHA block grant. Michigan's allocation from the block grant increased from $12 million in 1988 to $43.8 million in 1993. The 2008 grant is estimated at $59.3 million.

The third significant event was the establishment of a Medicaid substance abuse services program in the early 1990s. In 1998 the program was rolled into the capitated managed care program, referred to previously as the 1915(b) Medicaid Freedom of Choice Waiver.

In Exhibit A-14 please note that appropriations for the program have increased from $6.6 million in 1993 to $36.4 million in 2008.

Overall Spending by Coordinating Agencies

Section 408 of the MDCH annual appropriations bill requires that each coordinating agency report its previous year's total expenditures by fund source and program. The MDCH compiles the information and provides a summary report to the legislature by April of each year. Exhibit A-17 details the statewide MDCH expenditures for FY 2006. Overall expenditures were $136.9 million. Revenues generated by the local coordinating agencies represented $29.7 million, or 22 percent of overall expenditures. Included in the local revenue categories, however, are the Convention Facility Development Fund distributions described above. These are actually state revenues passed through to counties and then to the agencies. If they are excluded, local support decreases to $20.9 million, or 15 percent.

EXHIBIT A-17
Statewide Expenditures by Agency and Fund Source, FY 2006

Agency	ODCP	Medicaid	ABW*	MI child*	SDA	Fees	Local	Federal	Other	Totals
BABH/Riverhaven	$2,101,821	$1,340,675	$57,541	$586	$15,000	$129,171	$613,304	$0	$8,045	**$4,266,144**
Detroit Dept. of Health	17,804,286	7,217,270	350,805	0	1,110,207	416,777	3,710,019	0	0	**30,609,364**
Genesee County CMH	3,601,265	2,048,454	94,721	1,507	127,121	21,774	1,326,427	65	273,262	**7,494,596**
Kalamazoo County CMH	3,234,511	1,742,674	80,246	104	43,431	102,205	1,224,837	0	24,000	**6,452,008**
Lakeshore Coord. Council	3,943,859	993,211	107,931	3,273	24,218	85,563	1,455,050	0	208,297	**6,821,402**
Macomb County CMH	3,801,609	1,912,839	111,365	280	35,050	207,225	1,316,124	0	1,300	**7,385,793**
Mid-South Substance Abuse	6,353,833	1,956,917	157,045	1,800	120,961	264,202	2,313,385	83,038	100,396	**11,351,577**
Network 180	3,507,122	1,796,219	91,146	1,337	180,468	13,590	3,555,560	0	0	**9,145,443**
Northern MI Sub. Abuse	5,454,832	2,060,406	161,401	13,040	193,887	239,740	1,475,691	0	176,527	**9,775,524**
Oakland County Health Div.	4,504,047	1,919,361	103,831	13,192	176,391	232,639	2,270,731	456,670	0	**9,676,862**
Pathways Substance Abuse	2,208,537	662,290	32,681	2,954	139,399	32,724	351,664	100,000	0	**3,530,249**
Saginaw County Health Dept.	1,962,209	1,174,461	43,703	0	70,081	35,936	604,720	100,000	65,314	**4,056,424**
Southeast MI Comm. Alliance	6,623,181	2,946,402	199,277	3,430	29,831	94,484	1,727,892	0	35,121	**11,659,618**
St. Clair County Health Dept.	1,446,783	0	54,019	1,706	1,828	490,004	760,703	0	358,468	**3,113,511**
Washtenaw Comm. Hlth. Org.	2,589,209	857,205	43,283	42	38,190	5,620	1,317,481	0	500,577	**5,351,607**
Western U.P. Sub. Abuse	1,286,038	0	14,917	545	116,584	83,041	175,682	113,306	164,538	**1,954,651**
Salvation Army Harbor Light	3,980,408	0	0	0	0	178,768	81,929	0	0	**4,241,105**
Statewide Totals	**$74,403,550**	**$28,628,385**	**$1,703,913**	**$43,796**	**$2,422,647**	**$2,633,464**	**$24,281,199**	**$853,079**	**$1,915,843**	**$136,885,878**

* Federal share only
SOURCE: MDCH, *Substance Abuse Prevention, Education, and Treatment Programs*, April 2008.

LOCAL PUBLIC HEALTH OVERVIEW

Michigan's Public Health Code requires the Department of Community Health to "… continually and diligently endeavor to prevent disease, prolong life, and promote the public health…"[37] The Code defines basic health services and assigns the responsibility for determining those services and proposing methods for delivery and financing[38] to the Michigan Department of Community Health (MDCH). The MDCH has routinely exercised the option to deliver mandated services through the network of local health departments. Indeed, the Public Health Code recognizes the local health department as "the primary organization responsible for the organization, coordination, and delivery of those services and programs in the area served by the local health department."[39] The Public Health Code requires county boards of commissioners to establish local health departments with duties and responsibilities parallel to those of the state.

Today the 45 local health departments work to fulfill the code requirements by promoting and protecting the public health from ongoing threats such as pandemic flu outbreaks, bioterrorism, and infectious diseases. Each local department ensures that certain basic public health services are provided in their community such as safe drinking water, clean air, contained sewage, safe untainted restaurant food, the vaccination of children against disease, health care emergency response plans, the availability of family planning services, the investigation of diseases in order to prevent the spread of infections, and access to health care for all populations. The local departments also operate programs that promote the prevention of diseases caused by smoking, injuries, diabetes, lead poisoning, etc. In addition, almost all of the local health departments operate county or regional health plans that provide basic outpatient services to the working poor and indigent populations in their communities.

History

Michigan's public health system began in 1873 with the creation of a State Board of Health. The State Board eventually evolved into the MDCH. In 1996 the former Michigan Department of Public Health was combined with Mental Health, Aging, Substance Abuse, and Medicaid to form the MDCH. Food safety functions were transferred to the Department of Agriculture and water and sewer functions to the Department of Environmental Quality.

The First 100 Years

In observance of its centennial anniversary, the MDCH published a report, T*he First 100 Years*. Highlights from that report related to local public health are summarized below.

- 1873—The State Board of Health is established, the fifth such state agency in the nation.

[37] Public Act 368 of 1978, the Public Health Code, Section 2221.
[38] Public Act 368 of 1978, the Public Health Code, Sections 2301, 2305, 2471.
[39] Public Act 368 of 1978, the Public Health Code, Section 2235.

- 1917—The first effort to set up a larger local unit for health supervision is made with the passage of a law authorizing the formation of health districts composed of townships and villages.
- 1919—The State Board of Health is abolished. Powers and duties of the board are vested in a State Commissioner of Health assisted by an advisory group, the State Council of Health.
- 1927—County boards of supervisors are given the authority to establish county or district health departments.
- 1958—With the encouragement of the State Health Department, city and county health departments located in the same county began to consolidate so as to provide better health services to the public.
- 1961—Sixty-nine of Michigan's 83 counties are served by local health departments.
- 1965—New legislation makes it mandatory that all Michigan counties establish a local health department.
- 1965—Legislation cuts principal state agencies from 120 to 19. As part of this legislation, a new Department of Public Health is created incorporating most of the functions of the former State Health Commissioner, Crippled Children's Commission, Board of Alcoholism, and Veterans' Facility.
- 1966—All counties in Michigan are served by full-time health departments.[40]

The 1978 Public Health Code

Three major studies between 1966 and 1973 served as the framework for the first comprehensive public health code enacted in 1978. Common themes among all of these studies were the development of a comprehensive code that clearly defines the services to be delivered by local public health departments, and their governance structure. All three included recommendations that would strengthen the partnership between the state health department and local health departments. The studies also agreed that there was a need for increased accountability standards for local health departments and in exchange, the state's share of public health funding would be significantly increased.

The three studies are summarized below:

- The *Michigan Community Health Services Study* was released in 1966. The study was more commonly referred to as the Committee of Forty Report and included 61 recommendations. The committee examined community health needs and the appropriateness with which they were being met, focusing on patterns of organization and funding.[41]
- In 1973 the second study was commissioned by the Department of Public Health. The Citizens Research Council (CRC) prepared the report, *A Study of Organization for the Delivery of Local Health Services in Michigan*. The report analyzed "…the current

[40] Michigan Department of Community Health, *The First 100 Years* (Lansing, Mich.: MDCH, 1973), 50–78.
[41] Michigan Department of Community Health, A Review of the First Five Years, State/Local Cost Sharing In Michigan (Lansing, Mich.: MDCH, 1986), 1.

organizational infrastructure for delivering local public health services, concentrating on organizational weaknesses and developing recommendations for improvement."[42]

- As a follow up to the CRC study the Department of Public Health convened the Centennial Citizens Conference in 1973. The conference passed a resolution calling for the creation of the Public Health Statutes Revision Project. The project consisted of an 11-member, bipartisan Legislative Council Committee and a 12-member Governor's Commission, and six work groups. The recommendations focused on improving the relationship between state and local health departments and served as the basis for the 1978 Public Health Code.[43]

Statutory Mandates and Governing Structure

The public health system continues to operate under the provisions of the 1978 Public Health Code, as amended. The code establishes the MDCH as the focal point for public health protection in Michigan. It defines basic public health services and assigns leadership to MDCH to determine priorities and the means for delivery of those services. The MDCH has routinely exercised the option to deliver mandated services through the network of local health departments. The state executes agreements with the local health departments to assure accountability; the agreements set out the state/federal funds to be provided to support the contracted services. The agreements also require the local health departments to participate in an accreditation process. As of June 2008, all 45 local health departments are fully accredited.

Local Governance Structures

Part 24 of the code requires county boards of commissioners to establish local health departments with duties and responsibilities parallel to those of the state.

The 1978 health code provided for alternative governing structures at the local level. A "local governing entity" may be:

(a) In the case of a single-county health department, the county board of commissioners.
(b) In case of a district health department, the county boards of commissioners of the counties comprising the district.
(c) In case of a district health department which includes a single-city health department, the county boards of commissioners of the counties comprising the district and the mayor and city council of the city.
(d) In case of a single-city health department, the mayor and city council of the city.
(e) In the case of a local health department serving a county within which a single-city health department has been created pursuant to section 2422, the county board of commissioners elected from the districts served by the county health department.[44]

Michigan's 45 local health departments include 14 district health departments, 30 single-county health departments, and one city health department. District Health Department

[42] Ibid., 2.
[43] MDCH, *A Review of the First Five Years*, 3.
[44] Public Act 368 of 1978, the Public Health Code, Section 2406.

No. 10 includes ten counties and a population of 267,000. Huron County, population 36,640, is the smallest single-county health department. The City of Detroit is the only city that qualifies to form a health department, since the code sets the minimum population threshold at 750,000.

In district health departments, the board of health (composed of two commissioners from each participating county) serves as the board of directors of the health department, appointing the health officer and medical director and establishing policies. In a single-county organization, the board of commissioners or county executive exercises direct control over the health department, appointing the health officer and medical director and establishing policies, unless a board of health is appointed with specifically delegated duties and responsibilities specifically delegated by the board of commissioners. The responsibilities and qualifications for health officers and medical directors are defined in the code and administrative rules.

State and Local Cost Sharing

The main goal of the new health code was to strengthen the partnership between state and local health departments. The local health departments were to become more accountable in return for receiving a significant increase in funding from the state. Accountability meant that the local departments would be subject to a set of minimum performance standards. Funding would be increased from 20 to 50 percent of the costs of providing "required" and "allowable" services. These funding increases would be phased in over a four-year period. The new financing structure was referred to as state and local cost-sharing.

The new code attempted to distinguish between "basic" health services, "required" services, and "allowable" services. The code directed the MDCH to develop a list of "basic" services that must be provided by each local health department. "Required" services included the list of "basic" services for which appropriations are made, as well as other services mandated in statutes or administrative rules.[45] "Allowable" services are not mandated but are eligible to receive state funding.[46] Over the years the MDCH has worked with local health departments and other community partners to develop and update the list of "basic," "required," and "allowable" services.

Each year the state must publish the list of "basic" services. Traditionally "basic" services have been identified in the annual budget bill. Section 218 of the 2008 MDCH budget bill defines "basic" health services as immunizations, communicable disease control, sexually transmitted disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, newborn screening, emergency management planning, and prenatal care.

The definitions of these services became very important because they were tied directly to the new funding. The code provided that state funding for "required" and "allowable" services increase to cover 50 percent of the cost. In the first year of the program, funding was increased from $5.5 million to $16.2 million. After the first year the funds were

[45] Public Act 368 of 1978, the Public Health Code, Sections 2311, 2321, 2408(1).
[46] Public Act 368 of 1978, the Public Health Code, Section 2403(1).

reduced for a few years and then slowly increased. From 1979 thru 1994 the cost-sharing program never exceeded 20 percent.

The decision to allow local health departments to cost share "allowable" services when combined with double digit inflationary increases may have contributed to legislative reluctance to expand financing to a 50 percent match. In 1986 the MDCH released a study, *A Review of the First Five Years,* which concluded:

> …In 1978 when the Code was under debate in the Michigan legislature, projections were made concerning total state support that would be required to finance the program at 50-50. At the time it was anticipated that 50-50 funding would require a $50 million state match. Although the projection was based on total local eligible service expenditures, the subsequent influences of double-digit inflation and program expansion could not be considered. The impact of these factors has been significant. As of 1984, the local base eligible for cost sharing was $92,096,190, an amount almost double the original projection."[47]

Governor John Engler's 2005 budget recommendation increased cost sharing from $18 million to $33 million. Eligible services were redefined to include only eight required services, and the local match was revised to include locally generated first-party fees in addition to county and city General Fund appropriations. The only year that the state achieved the 50 percent match outlined in the code was 1995.

In the late 1990s, state officials became concerned that the amounts required to support 50-50 cost-sharing were increasing faster than were state revenues. Once again a decision on the definition of the base may have doomed the goal of achieving a 50-50 share. In this case that decision was to allow state match for locally generated first-party fees. In 1999 the governor proposed and the legislature enacted an appropriation bill that changed the state and local cost-sharing program into what is in essence a block grant program entitled "local public health operations" (LPHO). Section 904 of the 2008 MDCH budget bill allocates the LPHO funds to support immunizations, infectious disease control, sexually transmitted disease control and prevention, hearing screening, vision services, food protection, public and private water supply, and on-site sewer management.

Other States' Governance and Financial Structures

The governance structures of state and local health departments vary greatly among the states and within the states. A report published in 2006 by the National Association of County and City Health Officers (NACCHO), *2005 National Profile of Local Health Departments*, found that local health departments (LHDs) in the United States serve a variety of different jurisdiction types with populations ranging from less than 1,000 to nearly 10 million.[48] The study summarizes the governance and jurisdiction structure of local health departments as follows:

- 73 percent of LHDs serve a county or combined city-county jurisdiction.

[47] Michigan Department of Community Health, *A Review of the First Five Years*, 21.
[48] National Association of City and County Health Officers, *National Profile of Local Health Departments 2005* (Washington, D.C.: NACCHO, July 2006), Chapter 2.

- 62 percent of LHDs serve small jurisdictions (populations of less than 50,000), but these small jurisdictions account for only 10 percent of the U.S. population.
- A majority of the U.S. population (approximately 54 percent) lives in the jurisdictions of the 6 percent of LHDs that serve populations of more than 500,000.
- 79 percent of LHDs operate as units of local government.
- 74 percent of LHDs serve a jurisdiction with a local board of health.
- 12 percent of LHD jurisdictional boundaries overlap with the boundaries of a federally recognized tribal government.[49]

Chapter 3 of the study examined LHD financing for fiscal year (FY) 2005. The annual budgets for LHDs range from less than $10,000 for several New England boards of health to $1 billion for New York City. FY 2005 expenditures in Michigan range from $1.5 million for the Ionia Health Department to $104 million for the City of Detroit.

Statewide median per capita expenditures in 2005 ranged from a low of $9 in Massachusetts to a high of $94 in Maryland. Nationally the mean per capita LHD expenditure was $41 and the median was $29. Michigan's mean and median per capita expenditures were $52 and $42, respectively. Michigan's per capita expenditures ranged from a low of $15 in Kalamazoo to $153 in the Luce, Alger, Mackinac, Superior District Health Department (LMAS).

Funding for LHDs come from a variety of sources: local, 29 percent; state direct, 23 percent; federal pass through, 13 percent; other, 12 percent; Medicaid and Medicare, 11 percent; federal direct, 7 percent; and fees, 6 percent. Michigan's LHD revenue structures are very similar to those of other states. Local revenue, at 33 percent of the total, is slightly higher than the national average of 29 percent. Direct state revenues, at 21 percent, are slightly lower than the national average of 23 percent.[50]

Funding History

This report presents a 20-year state appropriations history for the aging, mental health, and substance abuse networks. It was not possible to put together such a history for local public health because the state appropriations are buried in numerous program lines. This report does, however, provide a history of overall funding for LHDs going back to 1980. The funding history for 1980 and 1984 was obtained from the previously mentioned publication, *A Review of the First Five Years*. The 1986 and 1990 data are based on a handout from a 1991 MDCH accounting seminar. Data for the remaining years, 1996 through 2006, were obtained from a LHD Financial Database compiled by the Michigan Association for Local Public Health.

Exhibits A-18 and A-19 display the overall LHD expenditures broken out by fund source. Unlike the funding distribution in the other networks, more than half of the annual LHD revenues are generated locally. For instance, in fiscal year 2006 overall spending was budgeted at $523.5 million with $152 million coming from city and county General

[49] Ibid., Chapter 3.
[50] National Association of City and County Health Officers, *National Profile of Local Health Departments 2005*, Chapter 3.

Funds, $61.5 million in first- and second-party fees, and $53 million in third-party fees. Examples of first- and second-party fees are restaurant licenses and fees for copies of birth certificates. Third-party fees include reimbursements from Medicare and Medicaid for direct services provided by LHDs.

EXHIBIT A-18

Local Health Department Funding Sources, 1980–2006

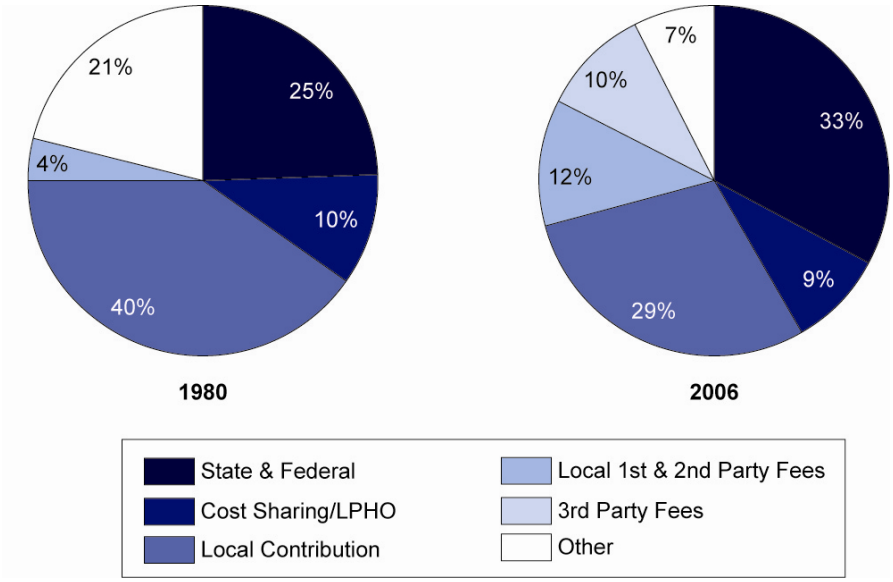
	1980	1984	1986	1990	1996	2001	2004	2006	% Increase 1980–2006**	% Increase 1986–2006**
State and Federal Categoricals	$38.76	$52.71	$60.09	$80.22	$136.55	$167.20	$163.83	$172.20	344.3%	186.6%
State and Local Cost Sharing/LPHO	16.18	17.86	19.06	19.58	32.34	41.07	40.62	38.10	135.5	99.9
Other Sources	32.94	23.23	16.33	27.12	25.14	22.57	37.20	46.37	40.8	184.0
Local Contribution	63.77	92.10	107.63	115.61	96.02	117.00	140.77	152.30	138.8	41.5
Local First and Second Party Fees*	6.30	22.70	34.18	48.10	30.71	36.60	53.66	61.54	876.8	80.0
Third Party Fees—Medicaid and Medicare	0	—	—	—	73.20	42.20	43.58	52.95	—	—
Total	**$157.95**	**$208.6**	**$237.29**	**$290.63**	**$393.96**	**$426.64**	**$479.66**	**$523.46**	**231.4%**	**120.6%**
Detroit CPI	82.3	102.4	108.1	126.8	151.6	173.8	184.4	195.9	138.0%	81.2%

Note: Dollars in millions.
SOURCE: 1980 and 1984 amounts based on MDCH publication "A Review of the First Five Years," State/Local Cost Sharing in Michigan, Figure 1; 1986 and 1990 amounts based on MDCH Accounting seminar in 1991; 1996, 2001, 2004, 2006 based on MALPH LHD Financial Database.
*Estimate for 1980 based on 1978 collections of $5.7 million. Estimate for 1984 based on 1983 collections of $22.03 million.
**It is likely that third party fees were lumped in with first and second party fees in the eighties and early nineties. The percent increase for all fees was 1717% from 1980-2006 and 235% from 1986-2006.

Between 1980 and 2006 total LHD funding increased by 231 percent. Local government General Fund contributions increased by 139 percent, local first-, second-, and third-party fees by 1,717 percent, and cost sharing/LPHO by 136 percent, compared to an increase in the Detroit Consumer Price Index (CPI) of 138 percent. In 1986, first-, second-, and third- party fees represented only 4 percent of total revenues, compared to 22 percent in 2006. Overall local contributions decreased from 40 percent of the total revenues to 29 percent (see Exhibit A-19).

EXHIBIT A-19

Local Health Department Funding Sources, FY1980 and 2006



SOURCE: 1980 amounts based on MDCH publication, *A Review of the First Five Years, State/Local Cost Sharing in Michigan*, Figure 1; 2006 based on MALPH LHD Financial Database.

For the 20-year period beginning in 1986, overall funding increased by 121 percent. Local government General Fund contributions increased by 41 percent, local fees increased by 235 percent, and cost sharing/LPHO increased by 100 percent. Over the same period, the Detroit CPI increased by 81 percent.

There were two major changes in state funding for local public health over the last 20 years. In 1994 the legislature increased tobacco taxes as part of the school finance reform package known as Proposal A. Six percent of the 50-cent increase in tobacco revenues was earmarked to the Healthy Michigan Fund. Initially almost all of the $30 million plus dollars went to support prevention programs. Budget reductions over the last six years have resulted in a shift of almost $18 million as a funding source to the Medicaid program. The second major change was the increase in state funding for the cost-sharing program in fiscal year 1995 from $18 million to $33 million. Cost sharing/LPHO funding peaked at $41.1 million beginning in fiscal year 2001. In FY 2008 cost sharing is funded at $40.6 million (see Exhibit A-20).

EXHIBIT A-20
State and Local Cost-Sharing/LPHO, 1978-2008

SOURCES: MDCH, *The First 100 Years*, 1973; PA 131 of 1987; PA 175 of 1992; PA 94 of 1997; PA 519 of 2002; PA 123 of 2007.

In addition to the $40.6 million for LPHO, the state has provided state dollars (i.e., General Fund, state restricted, and school aid funds) for other programs such as immunizations, AIDS, smoking prevention, cancer prevention, teen health centers, pregnancy prevention, and family planning. Every appropriations bill includes a section titled "Total of Payments to Local Units of Government" that details state spending for purposes of complying with the Headlee amendment to the State Constitution. A review of this section shows that state spending on these other programs totaled $5.7 million in 1980, $5.9 million in 1990, $21.8 million in 2001, and $14.8 million in 2006. Please note that from 2001 to 2006 the state support actually declined by $7 million. Exhibit A-18 shows that over that same time period LHDs have increased their first and second party fees by $25 million. It would appear that the decline in appropriations for the LPHO grant and other categorical programs has forced the LHDs to find new sources of revenues such as fees, in order to support their programs.

Appendix B:
Review of Other States: Organizational Structures for Service Delivery and Promising Practices

INTRODUCTION

This section of the report summarizes a review of other states, including the organizational structures for aging, mental health, public health, and substance abuse, as well as innovations such as performance measurement and accountability tied to outcomes and the restructuring of long-term care systems. Regarding performance measurement and accountability linked to outcomes, the summary will describe selected state efforts to implement performance measures in contracts, report cards and, in some cases, the state's overall budgeting process. The review begins with a description of the organizational structures in ten other states responsible for the administration of services associated with aging, mental health, public health, and substance abuse prevention and treatment services.

DESCRIPTION OF OTHER STATE ORGANIZATIONAL STRUCTURES

The overviews of each of Michigan's local networks (Appendix A) touched briefly on how other states organize the delivery of services provided by the four networks. This section of the report summarizes a review of ten other states: Colorado, Florida, Indiana, Illinois, Kentucky, Massachusetts, Ohio, Oregon, Washington, and Wisconsin. All of Michigan's neighboring states were chosen for review as well as several others that are mentioned elsewhere in this section. Others were chosen to provide some additional geographic balance. For purposes of discussion the developmentally disabled system has been broken out separately in order to more specifically describe how other states are organized. The results of the review are summarized below:[51]

- Local Public Health—Eight of the states had a stand-alone Department of Public Health. In the other two states public health was part of a larger department of human services or community health. In nine of the states the delivery of services was primarily delegated to local health departments.
- Aging—In five of the states the Agency on Aging is located within a larger department of human services or community health. Five of the states had a stand-

[51] State of Colorado website, *http://www.cdhs.state.co.us/dmh*
State of Florida website, *http://www.dcf.state.fl.us/mentalhealth*
State of Kentucky website, *http://chfs.ky.gov/*
State of Illinois website, *http://www.dhs.state.il.us*
State of Indiana website, *http://www.in.gov/fssa/dmha*
State of Massachusetts website, *http://www.mass.gov*
State of Ohio website, *http://www.mh.oh.us*
State of Oregon website, *http://www.oregon.gov/DHS*
State of Washington website, *http://www.dshs.wa.gov*
State of Wisconsin website, *http://dhfs.wisconsin.gov*

alone department or agency. The local network in all of the states was the Area Agencies on Aging. In one state the AAA administered the Home and Community Based Waiver program for the developmentally disabled population.

- Mental Health—In seven of the states mental health was part of a larger department. Three of the states had a stand-alone department. Three of the states contract directly with providers. In the other seven states a local network contracts for the delivery of services. The local networks were county boards, regional non-profit agencies, or managed care organizations, or some combination.
- Substance Abuse—In seven of the states substance abuse was part of a larger human services agency. In two of the states it was located within a mental health department and in one instance it was part of the public health department. In the seven states where substance abuse was part of a larger department, they were located within a bureau, division, or agency of mental health. Four of the states contracted directly with providers. Four states contracted with a county board, one with a managed care provider, and one with a network of private nonprofits.
- Developmentally Disabled (DD)—In six of the states DD was part of a larger human service department. In all six of these instances, DD was located in a bureau, division, or agency separate from mental health. Three of the states had a stand-alone Mental Retardation or DD department. In only one instance was DD located within the stand-alone mental health department. In three states the state contracts directly with providers. In the other states a local network of county boards or non-profits contracts with providers.

In terms of comparing these other state's organizational structures to Michigan there are several key observations. The first is how remarkably similar the local network structures are for public health and aging. The second is that substance abuse is almost always located within a mental health department or bureau. Finally, DD services are almost always separate from mental health.

PROMISING PRACTICES

Kentucky Initiative in Health Services Contracting

While administrative efficiency is valued and pursued by both local and state government, accountability is increasingly becoming the focus of concern by many policymakers in both the legislative and executive branches of government. An example of how to transform a state's health services contracting process so that it becomes more outcome based is described in an article published by the *International Journal of Public Administration*.

In Kentucky, the transformation began when the Cabinet for Health Services engaged a research team from the University of Louisville to examine Kentucky's existing contracting system. In the first year of the project the team reviewed the existing memoranda of agreement (MOAs) that were used by Kentucky's local health agencies, mental health and mental retardation boards, and area agencies on aging. The team recommended numerous improvements including giving more prominence to service plans and budget documents, incorporation of outcome measures into the respective

service plans and budget documents, reducing the complexity of the contracts by eliminating statutory and regulatory references, and increased use of the Internet to link all documents that might be referenced in the MOA.

During the first year the research team also gathered information from other states about their attempts to enhance contracting practices, particularly regarding performance monitoring. A summary of those findings is detailed below:

Colorado

The Colorado legislature enacted legislation to standardize and streamline the state's health services contracting procedures. The new streamlined application process requires prospective vendors to include performance measures and to use a single application to seek funding from a variety of prevention, intervention, and treatment programs.

> …Grant applicants are required to link their program goals and outcomes to the performance indicators, but the state experienced difficulty in holding local agency programs accountable for changes in state, or even county specific performance measures. However, it was felt that linking local programs to statewide goals and performance indicators would be beneficial.[52]

Florida

"In 1994, the Florida legislature enacted the Government Performance and Accountability Act, which established performance-based budgeting in the state government. The process was phased in over a 7-year period…" After reviewing the process the state concluded that performance based budgeting may have limited utility because of the labor intensive nature of the system, its focus on governmental structure, and the lack of analytic and information capacity of government agencies. In addition, it failed to recognize that rational planning-based systems cannot replace the complex political process.[53]

Nebraska

"Nebraska has focused on improving accountability in public health programs by developing and monitoring performance-based standards and measures at all levels and in all programs. Nebraska's Public Health Strategy raised questions such as:

- What measures or indicators assess improvements in the public health system?
- Can increased financing for the public health infrastructure be linked to improved health outcomes?
- Does the current governance structure clearly identify who is responsible for protecting the public from health risks?
- Who is responsible for monitoring the quality of care?"[54]

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[52] Morse, John H., Steven G. Koven, Charles J. Mundt, and Stephan F. Ohmann, The Kentucky Initiative in Health Services Contracting: The Search for Contracting of Outcomes Measures, *International Journal of Public Administration* 31 (No. 6, May 2008), 644.
[53] Ibid., 645.
[54] Ibid., 645–646.

Virginia

"In 1995 Virginia's Department of Planning and Budget established a nationally recognized 'performance budgeting' process. This process was designed to establish priorities and was first used with the 1996–1998 biennial budget. Key reasons for including performance budgeting in its financial management included improving accountability, establishing a long term focus and providing a basis for prioritization of resources."[55]

Washington

"Washington State Department of Health develops a Public Health Improvement Plan for each biennium. The department also develops a set of core indicators for a Key Health Problem Report Card. In addition, state officials are testing standards to increase the accountability within the system. Washington is committed to a consolidated contract rather than multiple contracts with its local health departments and has developed a web-based system for the consolidated contracting process."[56]

During the second year of the Kentucky project the research team developed what they referred to as a Model Memorandum of Agreement to incorporate the team's recommendations for enhancing the MOAs. The team chose the local health department MOA as their best practice model. For the first few months a group of stakeholders that included state officials, state contract staff and local officials rewrote the local health department MOA. They wrote clearer and more concise definitions, added Internet linkages to other controlling documents, merged sections, and eliminated redundancies.

The research team assessed the reporting systems of the local health departments and compared them to the other state systems that were described above. They found that the locals often had good outcome data but the data was not readily available in a form they could easily utilize. The team recommended that each local health department should be given a report card that shows how their outcomes compare to each other and to the state's Healthy Kentuckian 2010 goals.

The research team also recommended that the Cabinet continue to develop outcome measures and reporting systems for all human service activities that are funded under the MOAs and to link all reporting systems in a common data warehouse. An Internet strategy report was developed that included a prototype for site content and an inventory of selected state websites.

The journal article concluded that the implementation of any such process in a human service agency requires substantial time and investment. All stakeholders must be involved from the beginning. The system should be continuously examined to determine useful outcome measures and deficiencies need to be addressed. Finally, the increased use of the Internet for data collection and reporting should be coupled with better performance measures that are more closely related to Kentucky's Healthy People 2010.

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[55] Morse et al., *The Kentucky Initiative*, 646.
[56] Ibid.

Budgeting for Outcomes

Fiscal crisis often inspires state and local governments to look at ways to improve accountability by tying spending to outcome measures. These budget techniques range from zero-based budgeting to performance-based budgeting to report cards. The most recent technique is budgeting for outcomes, which is described in the book, *The Price of Government*.

This book describes in great detail the implementation of the process in the State of Washington for the 2003–2004 biennium budget. The budgeting for outcomes process shifts the focus away from incremental budgeting and toward identifying the outcomes that matter most to the public. "There are 12 easy and not so easy steps:

1. Set the price of government: how much citizens are willing to spend.
2. Determine the priorities of government: the outcomes that matter most to citizens, along with indicators to measure progress.
3. Describe the price for each priority outcome.
4. Decide how best to deliver each priority outcome at the set price: Create steering organizations to act as purchasing agents and have them develop cause and effect strategy maps and purchasing strategies.
5. Set outcome goals and indicators for each of the strategies and programs, and make sure the results are measured.
6. Solicit offers, and then choose which programs and activities to purchase.
7. Negotiate performance agreements with those providers, spelling out the key outputs and outcomes to be produced, the indicators to be used to measure progress, the consequences for performance, and the flexibilities granted to help the organization maximize performance.
8. Eliminate line items in your budget below the program or strategy level; appropriate lump sums for the results of each strategy, so you know the real cost of each program and strategy.
9. Develop full cost accounting, which attributes all direct and indirect costs to a program or strategy, so you know the real cost of each program and strategy.
10. Create a process to review performance against the targets, in both the executive and legislative branches. Ideally, this should take place in executive-branch steering organizations and legislative committees organized to focus on the same outcomes.
11. Use data on results and performance management to drive improvement in programs, strategies, outputs, and work processes.
12. When performance dictates it, make changes in the organization chart, in both the executive and legislative branches."[57]

The budgeting for outcomes concept was implemented in varying degrees in numerous state and local units of government, including the states of Iowa and Michigan. In Michigan the process was used in the development of the 2005 and 2006 Executive Budget Recommendations and by the House of Representatives for 2006. The process was also implemented at the local level, e.g., the Kent County Health Department.

[57] Osbourne, David, and Peter Hutchinson, *The Price of Government—Getting the Results We Need in an Age of Permanent Fiscal Crisis*, (Basic Books, 2004), 91–92.

In Kent County, the health department found itself in a position similar to many local government entities: facing continuous funding reductions and a need to do more with less. In response, the leadership of the health department sought a way to use its resources more effectively and efficiently, and more closely align the department's resources with health outcomes that are highly valued by the community and consistent with evidence-based public health practices. The health department implemented the steps in *The Price of Government*, identifying and validating the outcomes sought by the community, establishing indicators of progress toward those outcomes, and aligning department resources to interventions that have the greatest impact on the outcomes. Programs are now identifying how monitoring and evaluation need to be strengthened in order to provide information on outcomes to continue guiding program prioritization and budgeting. The process used by the Kent County Health Department, which included documentation of evidence-based public health practice, may be helpful to other health departments moving to accountability for outcomes.

WISCONSIN'S FAMILY CARE

In 1998 the Governor and Legislature authorized a new approach to long-term care, Family Care. The program is currently being piloted in nine Wisconsin counties and is designed to provide cost-effective, comprehensive, and flexible long-term care that will foster consumers' independence and quality of life. Family care serves people with physical disabilities or developmental disabilities and frail elders.

"The program has two major organizational components:

- Aging and disability resource centers (ADRCs), designed to be a single entry point where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities.
- Managed care organizations (MCOs), which manage and deliver the new family care benefit, which combines funding and services from a variety of existing programs into one flexible long term care benefit, tailored to each individual's needs, circumstances and preferences."[58]

Last year the National Health Policy Forum visited Wisconsin Family Care sites. Their report concluded that "Wisconsin officials developed a groundbreaking program to help people navigate long term care services. The ADRC concept, which has become a model nationwide, is designed to serve as a single point of entry to information about a wide range of services to assist the elderly and individuals with disabilities and their families. The care management component, administered through CMOs, is grounded in the person-centered philosophy of care for which Wisconsin is known."[59]

The report also concluded that the program has resulted in cost savings. "A study of the cost comparisons has shown that, under Family Care, the average length of stay in nursing homes in 2006 was 5.5 months compared with 8.2 months under fee for service

[58] State of Wisconsin website, *http://dhfs.wisconsin.gov.*

[59] National Health Policy Forum, *Community-Based Long-Term Care: Wisconsin Stays Ahead—Site Visit Report* (Washington, D.C.: George Washington University, 2007), 10.

arrangements. The average cost of nursing home stays for individuals in Family Care was $19,371 as compared to $24,752 in fee-for-service."[60]

PROMISING PRACTICES IN LONG-TERM CARE SYSTEMS REFORM

In 2004 Medstat prepared an analysis for the U.S. Department of Health and Human Services that identified common factors that contributed to successful systems change in eight different states. The eight states and the different population mix in their systems change efforts are detailed below. Please note that one of these change efforts is Wisconsin's Family Care program discussed above and another one is Michigan's implementation of its managed care system for behavioral health services. Two common design features were single access points and person-centered services.

State	Case Study Populations
Colorado	Older adults and people with physical disabilities
Michigan	People with developmental disabilities, mental illness, or addiction
New Hampshire	People with developmental disabilities
Oregon	Older adults and people with physical disabilities
Pennsylvania	People with mental retardation
South Carolina	Older adults and people with physical disabilities
Vermont	Older adults and people with physical disabilities
Wisconsin	Older adults and people with physical or developmental disabilities[61]

The analysis identified eight essential change factors:

- Effective state leadership—experienced, effective, and sometimes visionary leadership from the state agencies.
- Participant Involvement—special efforts to involve program participants, self advocates, and family members in the decision-making process.
- A Shared Vision—defining a vision and establishing broad consensus on goals and values with the participants.
- Precipitating Event or Crisis—an event like a state budget crisis or a lawsuit that creates a sense of urgency to make changes.
- Political Champion—Gubernatorial and legislative support is critical.
- A Plan for Change—develop plans to achieve or at least move towards the shared vision or the common goals for redesigning the long-term care system.
- Staff Preparation—systems changes require major changes in the way state staff, case managers, and providers do their jobs.

[60] National Health Policy Forum, *Community-Based Long-Term Care*, 8.
[61] Eiken, Steve, Medstat Research and Policy Division, *Promising Practices in Long Term Care Systems Reform: Common Factors of Systems Change*, prepared for the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, 1.

- Multiple Changes over Several Years—smaller incremental reforms set the stage for all of these initiatives.[62]

SUMMARY

This section described a number of state initiatives to implement performance and/or outcome-based budgeting and contracting techniques. These included:

- The state of Washington's successful implementation of the "Budgeting for Outcomes" concept. The state also develops a Public Health Improvement Plan for each biennium and routinely issues report cards with indicators on the status of key health problems.
- The state of Florida concluded that their performance-based budgeting process was labor intensive and of limited utility in part because it ignored the political realities associated with such a complex decision-making process.
- In Michigan a local health department, Kent County, is implementing the budgeting for outcomes process in an incremental fashion, recognizing that many steps must be taken before outcomes are effectively integrated into resource decision making.
- Kentucky's Cabinet for Health has implemented a model contract for the delivery of local health services that includes outcome measures and illustrated the importance of making changes with stakeholder involvement.

In Michigan, the Executive Branch used a comprehensive budgeting for outcomes process for two years, using the key steps in *The Price of Government*, and the House of Representatives used the process for one year. Perhaps the lesson for state policy makers is that it may be easier to implement outcome-based budgeting, contracting, and decision making in incremental steps and in targeted areas such as human service agencies. Local health departments may be a good starting place because their responsibility for community health assessment and monitoring health status and other outcomes generates the type of data needed for accountability linked to outcomes.

This section also reviewed other states and how they structure their local delivery networks as well as examples of innovative practices in the restructuring of long term care systems. Michigan was one of the states cited as developing a successful implementation model for its managed care system for mental illness, developmental disabilities, and substance abuse disorders. One notable observation from the review of how other states are organized is that unlike Michigan's process, a more common model for the delivery of mental health services and services for the developmentally disabled is separate state and local structures. Also, Wisconsin utilizes separate delivery networks, but in their pilot program Family Care, they have combined the frail elderly population, developmentally disabled, and individuals with physical disabilities into a single long-term care system. A lesson to be learned from Wisconsin may be that in order to develop and implement a successful innovative practice, a state may link existing delivery networks.

[62]Eiken, *Promising Practices*, 2–6.

Appendix C:
Summary of Comments Unique to Each Network

AGING

Opportunities to Improve Efficiency and Effectiveness

- Most respondents said that the benefits of regionalization have already been realized in the aging network. A few respondents thought efficiencies could be achieved with further merger/consolidation of administrative functions within the aging network and with agencies in other service networks (those with similar missions and clientele), particularly through co-locating agencies, greater collaboration, and possibly consolidation in a few specific locales.
- Multipurpose organizations are already operating in some locales and can effectively use resources by sharing administrative costs across the agency, e.g., the Health and Community Services Department of Kalamazoo County and the Upper Peninsula's multipurpose agency, Upper Peninsula Commission for Area Progress (UPCAP).
- A majority of respondents indicated the potential for more effective collaboration and sharing of staff with other agencies is strong (e.g., mental health specialists could be housed at area aging agencies to assist Medicaid waiver care managers and increase referrals).
- Several respondents noted that aging, mental health, and substance abuse networks share clients who would benefit from further collaboration and coordination of services. For example, a significant portion of the developmentally disabled population is "aging" into the services provided by the area agencies on aging (AAAs). Coordination with local public health to provide joint outreach services and administrative functions such as shared management information services is another area that was mentioned.
- AAAs frequently share administrative functions with other AAAs, including contract development, training, and auditing providers used by contiguous AAAs. Other opportunities for sharing between AAAs could involve legal staff, payroll, purchasing, information technology, and human resources. Shared staff could include registered nurses, social workers, and registered dietitians. Shared service delivery models, including single point of entry, regional call centers, data systems, and deaf and hearing impaired services are also areas for potential cost savings.
- AAAs often leverage resources from diverse agencies to address issues common to the missions of all of the agencies (e.g., housing, transportation) and partner with other agencies, including the MDHS, the courts, the disability network, legal services, and less frequently with local public health, mental health, and substance abuse agencies.
- Cost-effective service delivery can be enhanced by revising the policies that
  - restrict certain agencies from applying to be single points of entry,
  - require audits by outside, independent agencies,

- establish the restrictive funding structure of the MIChoice Waiver and produce lengthy delays in processing Medicaid waiver applications, and
- require a certain percentage of funding to be used for specific services that are not always needed in every community.

Innovative Practices

- Outreach for all agencies would be enhanced with the development of a regional or statewide 211 system or a combined resource center model at the local level that would provide referrals for all four network services.
- Annual best practice reviews should be used to make adjustments in policies and practices, focusing on collaboration, out-sourcing/in-sourcing, and satisfaction surveys.
- Wayne County's Managed Care Provider Networks coordinate large numbers of providers and share administrative resources between agencies.
- A group of AAAs could share the costs of resource development (research, preparing grants, and joint purchasing).
- Building a high-quality system of long-term care for Michigan residents would assure cost-effective service delivery for the elderly and disabled in the state.
- Developing the video/teleconferencing capacity of the state would enhance remote communications and collaboration with distant service networks.

Barriers

- Most respondents indicated that a single community agency delivering all services is not feasible. Reasons cited include:
  - Governance (AAAs must exist as a separate entity), funding streams, purposes and missions specific to each type of agency
  - Different administrative practices and paperwork requirements
  - Cost savings to be accrued would be debatable
  - Previous failed attempts
  - Differences in the core competencies of staff; AAAs rely on volunteers
  - Diminished capacity to advocate for the population and provide quality services
- Data-sharing problems are huge. AAAs must use the National Aging Program Information System to record information about clients and services provided. For purposes of administering the Home and Community Based Waiver Program, agencies must use the Care Management Information System. Some duplicate data entry occurs.
- Respondents noted that state expectations for how AAAs operate are not particularly onerous because the state provides little administrative funding to the agencies.
- Challenges to sharing staff with other agencies include policy differences, differences in client eligibility, funding constraints, volunteer/paid staff mix, and differences in core competencies of staff.

- AAAs had more opportunities to work with local health departments when those agencies did more direct service work, such as providing primary care.
- Human services collaborative groups often are too narrowly focused on maternal and child health issues and represent a geographic area that is too small for effective AAA participation.
- State agency policies designed to protect consumer choice and conduct program monitoring have also made it difficult to achieve cost efficiencies, including the request for proposal (RFP) process and excessive reporting requirements (e.g., Michigan Automated Prescription System).

COMMUNITY MENTAL HEALTH

Opportunities to Improve Efficiency and Effectiveness

- Respondents identified a wide range of options for mergers/consolidations to improve efficiency and effectiveness:
  - The most frequently noted combination was CMH and substance abuse coordinating agencies (SACAs) because of the high frequency of dual diagnoses. Options cited ranged from close collaboration to co-locating to reduce administrative redundancy to sharing staff such as medical directors.
  - Integrating selected behavioral health, substance use disorder, and public health services with primary health care would be beneficial for the client (e.g., housing mental health staff at Federally Qualified Health Centers). In locations with no centralized primary care for the Medicaid population, co-location might be of limited benefit because the overlap of CMH clients with other agencies is small.
  - Locally initiated mergers between agencies have been found to be cost-effective service delivery systems (e.g., Pathways in the Upper Peninsula and Network 180 in Kent County).
  - One respondent suggested that aging could be merged with the prepaid inpatient health plans (PIHPs), but added that this could drive up overall costs because the lower compensation levels in aging would be raised to match PIHP compensation levels.
  - Some respondents noted that mergers between public health and community mental health would only be possible if each was a single county agency.
- Respondents noted that consolidation had already occurred to some degree with regionalization of the PIHPs. A few respondents noted that further consolidations within PIHPs and within community mental health service programs (CMHSPs) might be possible while others cautioned that consolidation does not guarantee better outcomes for clients.
- Some respondents noted that geographic alignment of (and/or merger with) the PIHPs and the SACAs could improve coordination between the service networks. A few respondents thought that benefits could also be gained by more closely aligning CMH territories with PIHP and SACA territories.
- Respondents noted the importance of keeping services based locally, but noted that it might be possible to share infrastructure functions with other agencies, including

- standardized billing and uniform contracts,
- electronic health care records, information technology, financial administration, training and data systems, and
- utilization management, customer and provider relations, after-hours response services, and other complimentary services.

- A shared administrative approach is feasible within the context of a common administration for more than one agency or with one agency performing these functions on behalf of the other. Mental health respondents highlighted the importance of addressing the eligibility determination role of the MDHS in such discussions.
- Housing the professionals from one agency in another agency may enhance service to a joint clientele (e.g., locating mental health professionals at the jail).
- One respondent noted that sharing staff among agencies may be limited by credentialing requirements and would most likely occur with paraprofessionals.
- Many clients of other service networks, including the judicial system, law enforcement, corrections, the MDHS, private, nonprofit child welfare providers, housing development organizations, and business groups, also have mental health service needs. Community mental health authorities routinely partner with those groups to address common clients and issues.

Innovative Practices

- Integrate intake services for substance abuse, mental health, and public health with co-location, cross training, and integration with primary care (e.g., Washtenaw Community Health Organization).
- Information exchange is being facilitated through the Regional Health Information Network, helping move service networks toward paperless, electronic records.
- State government should develop mechanisms to identify best practices and evidence-based approaches with the potential for systemic change. Conducting pilot studies to test the cost effectiveness of those approaches and establishing efficiency standards with appropriate rewards for meeting them is important.
- Affiliated mental health agencies could share human resources and administrative expertise more effectively among agencies, including establishing remote worker policies to allow employees to work for a number of different agencies.
- Client-centered programming in some communities has produced creative solutions, including multiple agencies sharing the case management function for a single client.

Barriers

- Many respondents noted that a lack of integration across the MDCH divisions and restrictive policies relative to local agencies contribute to the lack of integration between systems at the regional and local level. Examples of this include:
  - Separate service delivery systems within the MDCH
  - Separate Medicaid policies and procedures for each of the service delivery networks

- A lack of state-initiated and state-supported innovation and standardization of policies and procedures (e.g., a common definition for privacy and confidentiality, model contracts, and model person-centered planning documents)
- Arbitrary regional configurations not based on where consumers go for services and which are detrimental to the provision of community-based services
- Prohibiting case management and direct service within a single agency
- Many overlapping surveys and reviews of local and regional agencies conducted by different groups within the MDCH
- No uniform billing system and no integrated charting systems for substance abuse, PIHPs, and CMHs
- Excessively burdensome state reporting requirements (e.g., customer service requirements, Sections 460 and 404 reporting requirements, and person-centered planning)
- A costly and ineffective audit dispute resolution system

- Respondents cited many barriers to creating a single, super agency including:
  - Differences in community values and funding streams, (e.g., some agencies offer community-based services while others have a broader management role)
  - Increases to the size of the local bureaucracy
  - Political difficulties
  - Different federal and state statutes, regulations, reporting requirements, and auditing procedures, which perpetuate the service silos of human services agencies (e.g., substance abuse funding is non-Medicaid and mental health funding is Medicaid and statutory revisions of the Mental Health Code, Public Health Code, and the regulations for private nonprofit organizations would be necessary before further integration between agencies could occur)
  - Different staffing needs and standards
  - Cost
  - Previous failed attempts
  - Concern that the focus of the agency would be on the largest individual agency and the largest group of consumers
  - Increased insurance costs for the counties with reduced employee pools across which to spread risk
  - Administrative requirements for each of the agencies vary greatly; (e.g., little standardization of forms)
  - Few common elements among agencies; limited benefits and possibly high cost associated with co-location

- In light of significant local investment and variations, respondents had mixed opinions about the potential benefits of consolidating billing systems.
- State-driven collaborative efforts often fail to accommodate unique community characteristics.

- Implementing the Direct Care Wage increase mandated by the legislature is difficult and reduces cost-effective service delivery.

LOCAL PUBLIC HEALTH

Opportunities to Improve Efficiency and Effectiveness

- Most opportunities for regionalization within the public health service delivery system have already occurred, although there may be a few options for further consolidation depending on the will of the community and financial incentives to do so.
- Opportunities for integration and/or sharing with the aging and substance abuse service networks were more frequently and positively mentioned than opportunities for integration with community mental health. Integrating a SACA within a health department that provides primary care provides a critical health care link for clients. Opportunities for working with nontraditional partners, such as intermediate school districts and nongovernmental organizations are also available.
- The greatest opportunities for organizing services across agencies exist when different agencies are addressing common issues or a shared clientele and/or limited resources can be leveraged to address a common problem.
- Co-locating services can be beneficial for both the consumer and the organization regardless of whether the agencies are integrated or freestanding within a single physical structure. The challenges of co-location include privacy/confidentiality issues and the financial investment required to put such an organization in place.
- Sharing staff specialists, such as epidemiologists, surveillance specialists, and medical directors, may be possible depending on the size of the population served and the unique characteristics and needs of the community.
- Regional entities, such as the Southeast Michigan Health Association (SEMHA), can be instrumental in the effective use of funding from different locales for regional programs, including media communications, community health assessment, TB, and bioterrorism planning.
- Certain public health responsibilities may be best met on a regional basis, including the data analysis part of community health assessment, the provision of special services for a small number of clients, or special programs that cannot be delivered in a cost-effective manner by an individual agency (e.g., TB inpatient treatment, infectious disease surveillance, bioterrorism planning). Regional alliances to address specific issues are important, but the case management function should remain a local responsibility to retain the community-based focus.

Innovative Practices

- The multipurpose agency in Kalamazoo (Health and Community Services Department) has all but community mental health and substance abuse in the same organizational structure. Most respondents indicated that they thought this was a unique situation and noted that similar attempts to integrate services elsewhere in the state had been much less successful.

- It may be possible to promote further efficiency by sharing administrative functions between agencies, such as billing systems (possibly modeled after the Michigan Health and Hospital Association's service corporation) and information technology resources.
- Public health departments routinely partner with many other agencies, ranging from the agencies addressed in this study to private nonprofit agencies and other governmental entities, to address specific issues unique to their communities. Such collaborations are being encouraged as a condition of funding by foundations and nonprofit agencies such as the United Way.
- Evidence-based practices should be used to drive innovation in service delivery. The public health accreditation process can be used to identify best practices. Service models such as the dental clinic model offered by the Northwest Community Health Agency are being replicated across the state with various modifications specific to the locale.
- Evaluation of the mechanisms and formulae by which funding is distributed to local public health may be beneficial, e.g., one option might be use of an application process similar to that used with the Medicaid health plans.
- Joint state and local development of health promotion materials and marketing tools could produce cost savings by eliminating the duplication of effort that now takes place in each locale.
- Design a legislative initiative to examine innovative service delivery practices, especially those related to information technology and cost effectiveness relative to the communities served.

Barriers

- Local human service delivery systems are isolated from one another by state and federal statutes, regulations, and policies. The differences between agencies that limit the potential for cross-agency consolidation or merger include:
  - Funding streams
  - Staffing requirements
  - Governance
  - Unique relationships between the community and the agency
  - Organizational size and structure
  - Lack of financial incentives
  - Political opposition at both state and local levels
- Consistent and cohesive state polices and procedures for human services must precede any further consolidation of human services at the local level, including reintegration of environmental health with other public health functions at the state level.
- The extent of the challenges of working with other agencies with different service network boundaries varies by geographic location.
- State policies and procedures that contribute to a lack of integration of services and organizations at the local level include:

- Complex and lengthy requirements for billing and eligibility determination
- Frequent changes to reporting requirements
- Funding formulae that encourage competitiveness between health departments rather than collaboration and cooperation

- Data sharing problems are huge at both state and local levels.

SUBSTANCE ABUSE

Opportunities to Improve Efficiency and Effectiveness

- Much integration, including mergers and consolidations of coordinating agencies and CMHSPs, has already occurred at the local level; often driven by ever-declining funding as well as local initiative to improve or expand service delivery. Respondents clearly indicated that any further integration at the local level should
  - be community driven and recognize the unique history and circumstances of the locale;
  - follow a thorough analysis of cost effectiveness that demonstrates maintained or improved client services and sound business practices;
  - assure appropriate treatment for clients with co-occurring disorders; and
  - create a new entity consisting of co-equal partners which respects the values and cultures of each original entity.

- Respondents mentioned a number of specific options for mergers/consolidations including:
  - Combinations unique to a specific locale (e.g., merging the two coordinating agencies in the UP into a single agency)
  - Mental health and substance abuse (from a shared administration approach to sharing specific service components)
  - Public health and aging
  - Regionalization of CMHSPs
  - PIHPs and CMHSPs
  - Substance abuse and local public health

- About half of the substance abuse provider respondents thought some type of merger or consolidation of one or more of the service networks would be useful. Several providers cited the need for the merger of the MDCH and the Michigan Department of Corrections (MDOC) substance abuse services and several cited the need for the further consolidation or elimination of SACAs. Some respondents emphasized that collaboration between agencies was as important as consolidation or merger.
- Substance abuse provider respondents were about equally divided in their opinion that any one of the following three service networks (public health, mental health, and substance abuse) could assume delivery of the full range of services for all of the agencies; respondents were much less likely to say that the aging network could assume this responsibility.

- Most substance abuse provider respondents and a few respondents from CMHSPs and PIHPs thought that co-locating services with other human services agencies could be beneficial, citing central screening as a possible benefit.
- Administrative functions and direct services are often integrated or could be more integrated among SACAs, including access/authorization, coordination of services for the dually diagnosed, customer services, therapists and counselors, psychiatric services, medical directors, assessment services, IT services and staff, and administrative functions (i.e., referral services, shared claims processing staff, purchasing, transportation, grant writing, training, access, information sharing, contract monitoring, marketing, financial management, and clinical directors).
- Respondents spoke little of opportunities to coordinate with public health and aging, although health departments with a role in primary health care were seen as potential partners.
- One respondent thought using a single agency, such as public health, as an umbrella agency with autonomous agencies operating within it might improve efficiency.

Innovative Practices

- A broader implementation of a regional authority approach might provide the means to get around the complex set of state and federal statutes and regulations for human services.
- The state should support and encourage innovation by returning savings accrued, streamlining the intake processes for human services, adequately funding human services collaborative groups, disseminating information about best practices, and investing in research and development to redesign and redirect human service delivery in the state.
- Coordination among SACAs and primary health care, housing, mental health, social services, and other agencies offers many opportunities to enhance individual care and to address the problems of special needs populations.
- When integrating services, look to replicate the successful integration of services that has already occurred in some locales, such as Washtenaw County, Kent County, the Substance Abuse Prevention Department of Mid-South, and other locales.
- Application of the NIATx (Network for the Improvement of Addiction Treatment) Principles of Performance Improvement could help to reduce inefficiency in programs.

Barriers

- Unnecessary administrative duplication at the state level should be addressed before considering further consolidation at the local level (e.g., substance abuse programs operated by the MDCH, MDOC, and MDHS). Some respondents stated that they believe that the MDCH would have to be statutorily restructured to permit local organizations to blend functions such as information technology and human resources across service disciplines.
- Respondents believed that changing service network boundaries and further consolidating agencies is not a reasonable approach because it would

- require great political will to overcome local resistance,
- be costly,
- subvert mandated local control for substance abuse services,
- ignore differences in mission, staffing, service mandates, and funding streams,
- add another layer of bureaucracy, leading to increased inefficiency and complexity,
- dilute the identity of each individual agency,
- lower the quality of service provided to clients with addictions,
- subvert different governance and service mandates (e.g., confidentiality issues), and
- move accountability further away from local officials.

- State and federal mandates, regulations, policies, and practices that contribute to inefficient service delivery at the local level include:
  - Numerous rules and requirements that are duplicative and/or unnecessary
  - Separate block grant allocations for substance abuse and mental health
  - Ignoring data-sharing problems between the systems that exist by virtue of both federal and state requirements
  - Separate auditing for substance abuse and mental health services that is duplicative and expensive
  - Providing minimal guidance to local agencies because state resources are stretched so thin (e.g., little standardization in rate setting methodologies, contract templates, software, and database definitions)
  - Disseminating little information to local service agencies about evidence-based best practices
  - Requiring local agencies to meet burdensome state mandates, including Synar surveys and mandatory use of liquor tax revenues

- Given local investment and variations, consolidating administrative functions such as billing would be challenging.
- Challenges to sharing staff between agencies include cost effectiveness, different personnel policies, and different core competencies required for staff.

PERSPECTIVES OF OTHER STAKEHOLDERS

Legislators

The following themes emerged from interviews with five health policy and appropriations legislative leaders:

- The legislature is concerned about the value gained from public investments: Are program outcomes evaluated? How is value assessed?
- Are the service networks addressing the needs of communities? Is there capacity in communities for determining needs and the best ways to meet them? Is there capacity

at the local level to apply what they learn in order to meet needs more effectively and efficiently?

- It is important to engage municipalities and the judiciary regarding the capacity of local service networks, e.g., community mental health, to address the mental health needs of communities.
- More clear information about administrative cost is needed for comparative purposes.

County Commissioners

The following themes emerged from a focus group with four county commissioners from across the state:

- Consistent regional boundaries would encourage the cost-effective use of resources.
- It may be possible to combine mental health and aging; it may be possible to combine mental health and public health. It will vary at the local level.
- In any combination of agencies at the local level, the autonomy of the local agencies must be maintained. There may be an optimal geographic and population size for consolidation.
- Any consolidation must come from within the region itself rather than from the state. There would be costs associated with any regionalization that would have to be borne by state and local government and an educational campaign on advantages would be needed.
- Cross-agency collaboration and regionalization that are happening now are the result of agencies sharing a common agenda. This approach should be broadly disseminated.
- Unfunded mandates from the state are a problem, e.g., the mandatory services for public health are not fully funded as promised; neither are county medical facility services for those who can't pay. Local laws may also be a problem.
- Examples of recent innovations include mental health and economic development creating micro business loans for developmentally disabled adults; Dental Clinics North; Ingham Health Plan; and sharing of services among the hospital, jail, and county medical facility.

Judges

The following themes emerged from interviews with five judges, representing both circuit and probate courts in urban and rural counties:

- Maintaining and improving service delivery should be the primary goal of change in the delivery of human services—making an organization either bigger or smaller does not guarantee that the agency has a greater capacity to meet community needs. The focus should be on improving the continuum of care and reducing gaps and redundancies rather than maintaining the service silos that have existed for so long.
- Shared staffing and program arrangements already exist, most frequently between CMHs and the courts. There is need for more extensive coordination between the courts and SACAs and for further coordination with the MDHS and school districts.

- Potential combinations of agencies include mergers of CMHSPs and SACAs and combining specific functions (e.g., case management and family interventions) of the CMH, local public health, and SACA.
- A larger regional agency or a merged agency could make the individual agencies less adaptable and flexible and any individual agency could see a decline in service for its clients. It may be possible to use regional teams with specialized training to serve dually diagnosed clients in a more rural, multi-county area.
- Examples of innovative practices meriting further examination include school-based services, family courts, community-based intervention models, substance abuse courts, truancy courts, wraparound programs, and family therapy approaches.
- Independent analysis should be conducted to assess human services needs in the state so that the delivery system can be appropriately configured to meet those needs.

Michigan Department of Community Health Respondents

The following themes emerged from interviews with administrators in aging, community (public) health, mental health, and substance abuse:

- Although progress (e.g., bringing more uniformity to the purchasing and contracting functions of each service component) has been made with the merger of the service delivery networks within the MDCH, better coordination between public health, mental health, and substance abuse at the state level is needed (e.g., site reviews and audits of local agencies could be coordinated more effectively). Further consolidation of functions at the state level is hampered by a lack of staff and funding. Improved service delivery is an essential component of any evaluation of cost effectiveness.
- Statutory mandates, funding streams, and history are unique to each service delivery system and related to the wide range of variation in the services available to each of the consumer populations they serve.
- Further regionalization with the public health, aging, and mental health systems may be possible, probably in the more rural areas of the state. Consolidation of substance abuse with public health may be possible in some locales, although federal and state funding restrictions and service mandates would make this challenging. Close-out costs as well as the potential for loss of local autonomy/control and local financial support would also be likely. In addition, the advocacy capacity and the ability of each individual agency to be responsive to the needs of its consumers would be concerns.
- Financial incentives could be provided by the state for those communities considering mergers, co-locating, and other forms of consolidation, including the development of shared information technology systems, Web-based reporting systems, and the integration of publicly funded primary care with the human services networks. Integrated billing system might be possible, providing local variations can be accommodated.
- Administrative functions such as contract management/monitoring and joint programming for shared clientele offer some of the best opportunities for sharing services and staff among the various types of agencies. Collaborative approaches to address the needs of a common clientele should also include the MDHS (eligibility

determinations), the Michigan State Housing Development Authority (MSHDA) (e.g., homelessness), the courts, municipalities, and corrections. In some instances, the overlap is programmatic (e.g., serving clients with a dual diagnosis), while in others, enhanced collaboration might reduce costs with bulk purchasing and shared administrative approaches.

- Managed care has allowed the state to shift significant portions of its mental health expenditures from General Funds to federal funding.
- Single point of entry is a needed, cost-effective approach that will enhance long-term care in the state.
- Michigan's local public health accreditation process can be used to identify and disseminate best practices.

State evaluation/oversight of local service delivery systems could be improved through a variety of mechanisms, including more extensive use of consumer satisfaction surveys, program evaluation, multi-year planning requirements, uniform reporting requirements, requiring collaboration at the local level, and peer review.