DRAFT – Agenda
Tuscola County Board of Commissioners
Committee of the Whole – Thursday, March 14, 2013 - 7:30 A.M.
HH Purdy Building - 125 W. Lincoln, Caro, MI

Finance

Committee Leaders-Commissioners Kirkpatrick and Trisch

Primary Finance Items

1. **Step 3 Compliance State Revenue Sharing (See A)**
2. **FLMA Request (See B)**
3. **Jail Expenditures, Overcrowding, Potential Short/Long Term Solutions (See C)**
4. **Potential Agreement for Dental Clinics to Serve Uninsured (See D)**
5. **Potential Re-Use of Camp Tuscola**

Secondary/On-Going Finance Items

1. Denmark Township Debt Repayment
2. Bidding County Health Insurances
3. Affordable Care Act
4. Development of Financial Projections for Labor Negotiations and 2014 Budget Preparation
5. Prepare Bids for the 2013 County Comprehensive Annual Financial Report (Audit)
6. Medical Care Facility Small House Project Update
7. State Revenue Sharing, PILT, Indigent Defense
8. Health Department Parking Lot Improvements
9. Amalgam Next Steps
10. Fracking Assessing/Taxation

Personnel

Committee Leader-Commissioners Kirkpatrick and Trisch

Primary Personnel Items

1. **County Planning Commission Vacancy (See E)**
2. **HDC Senior Citizens Advisory Council Vacancy (See F)**

Secondary/On-Going Personnel Items

1. New Hire Wage/Fringe Benefits
2. Impact of Right-to-Work on Tuscola Unions and Negotiations
3. Preservation of the Joint Tuscola/Huron Equalization Director
4. Court Personnel Policy Revisions

Building and Grounds

Committee Leader-Commissioners Allen and Beirlein

Primary Building and Grounds Items

1. **20 Year Capital Improvement Plan (See G)**
2. **Maintenance at the State Police Building**

Secondary/On-Going Building and Grounds Items

1. Xoom Energy Savings Assessment
2. Update to the County Solid Waste Management Plan – EDC

Other Business as Necessary

1. Dredging Funding Potential
2. Declining Great Lakes Water Levels and Potential Solutions
3. BC/BS Access Fees Lawsuit

Public Comment Period

Closed Session – If Necessary

Other Business as Necessary

Statutory Finance Committee

1. Claims Review and Approval

Notes:

Except for the Statutory Finance Committee, committee meetings of the whole are advisory only. Any decision made at an advisory committee is only a recommendation and must be approved by a formal meeting of the Board of Commissioners.

If you need accommodations to attend this meeting please notify the Tuscola County Controller/Administrator's Office (989-672-3700) two days in advance of the meeting.

This is a draft agenda and subject to change. Items may be added the day of the meeting or covered under other business at the meeting.

(A)

Brown & Brown INSURANCE

1605 Concentric Blvd., Suite #1, Saginaw, MI 48604 ~ Phone: 989-249-5960 ~ FAX: 989-249-5966

February 26, 2013

Mr. Michael Hoagland, County Administrator
Tuscola County
207 E. Grant Street
Caro, MI 48723

Re: PA 152 Hard Cap Estimate for 9/1/12-8/31/13 Plan Year

Dear Mr. Hoagland,

Brown and Brown of Central Michigan has completed a financial estimate of your current BCBSM health plans under PA 152. The following is our findings:

TUSCOLA COUNTY& HEALTH DEPT.
PA 152 HARD CAP PROJECTION 9/1/12-8/31/13

CONTRACT TYPE	CENSUS	PPO 4 RATES	1% CLAIMS TAX EST.	EMPLOYER COST PER MONTH	EMPLOYER COST ANNUAL	CAP AMOUNT
SINGLE	24	$407.31	$4.07	$411.38	$4,936.60	$5,500.00
2-PERSON	34	$977.55	$9.78	$987.33	$11,847.91	$11,000.00
FAMILY	88	$1,134.19	$11.34	$1,145.53	$13,746.38	$15,000.00
TOTALS	146	$142,821	$1,428	$144,249	$1,730,989	$1,826,000

PROJECTED HARD CAP: ($1,826,000)

MINUS PROJECTED EMPLOYER COST: $1,730,989

MINUS PROJECTED OPT OUT PAYMENTS: $51,527

OVER/(UNDER) HARD CAP: *($43,484)*

Assumes all employees eligible enrolled
All quotes based on BCBS Illustrative Rates effective 9/1/12
No dental or vision included
Based on Hard Caps in effective on 9/1/12
Does not include any employer contributions to a Retiree Health Savings program (RHS) or Health Care Savings Program (HCSP).

We are estimating that you are $$43,484 under the "hard cap" for the plan year beginning September 1, 2012. This estimate does not include any employer contributions to a Retiree Health Savings program (RHS) or Health Care Savings Program (HCSP). If you are making such payments then these will count against your hard cap per the most recent FAQ published by the Michigan Department of Treasury.

This estimate is based on information received from BCBS, the County and the State of Michigan. This does not constitute legal advice and you should consult your legal counsel for legal guidance.

We remain committed to giving you the highest level of service and look forward to working with you during the coming year. Please feel free to contact me if you have any questions.

Sincerely,

Daniel Skiver
Vice President
Brown and Brown of Central Michigan
dba Public Employee Benefits Solutions

(B)

Commissioners

The County Human Resources Director (HR) will be taking a Family Medical Leave Act (FMLA) anticipated in August of this year. She plans to use the full allowed 12 weeks according to the act. I need to make provision to maintain office operations during this period when there will only be two full-time employees and myself in the office.

There are numerous day-to-day HR functions that have to be performed. The office has been reduced by two full-time employees since 2010 from six to four. There has also been turnover in the HR position with a learning curve for the current HR. It is not possible for the remaining two employees to pick up the work load of the full-time HR. Also, at this time of year office demands peak with the budgeting, contract negotiating process and Affordable Care Act underway along with all of the other daily functions that have to be performed. The Board of Commissioners has authorized temporary assistance for other offices in the past while an employee is on FMLA.

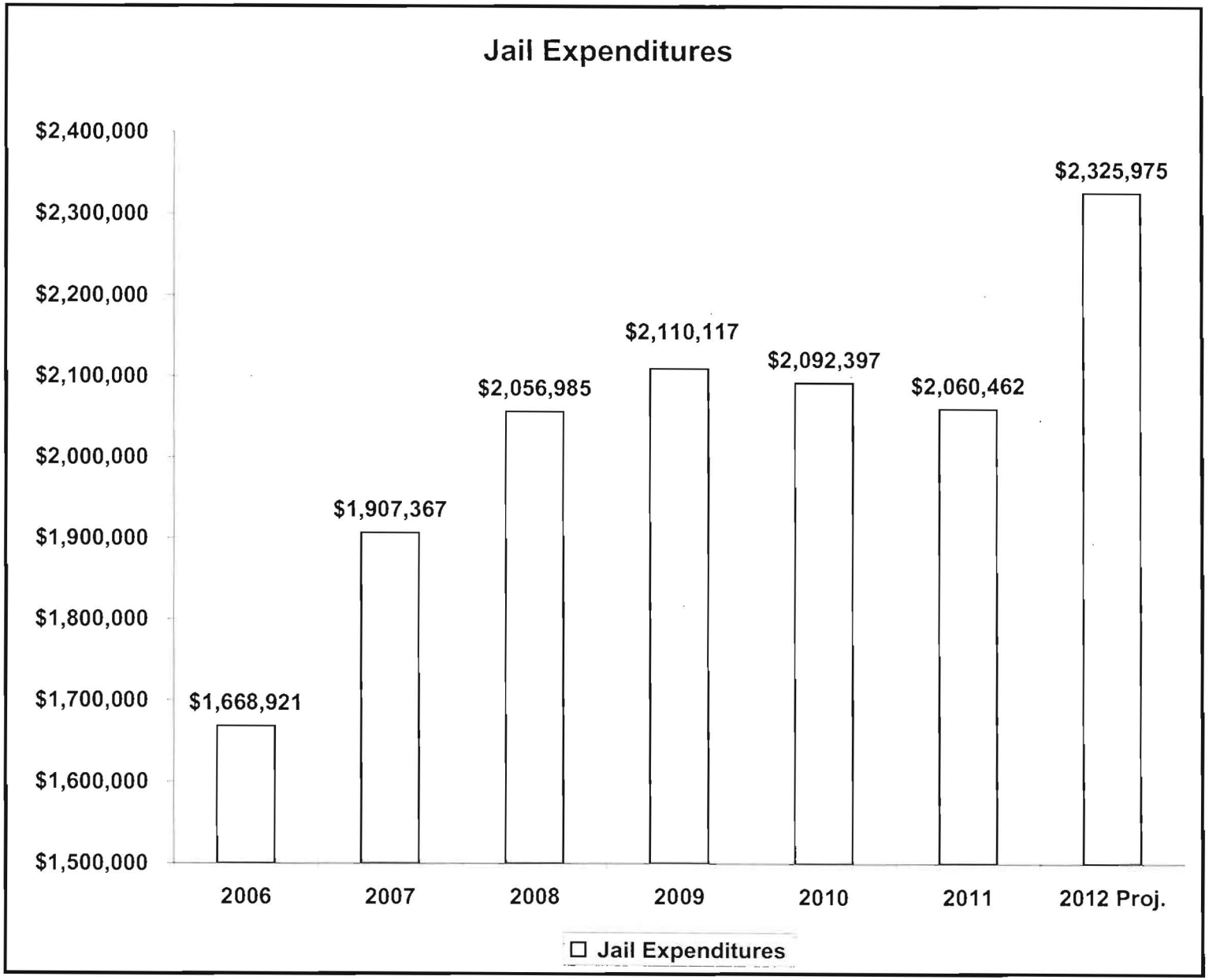
I have inquired with a retired former employee of the Controller/Administrator's Office to determine if she wanted to come back on a temporary basis while the HR is on FMLA but she declined. The only other option is the use of a temporary service company. I have inquired with Corner Stone Services in Caro. The amount charged by Cornerstone Services is $20.70 per hour.

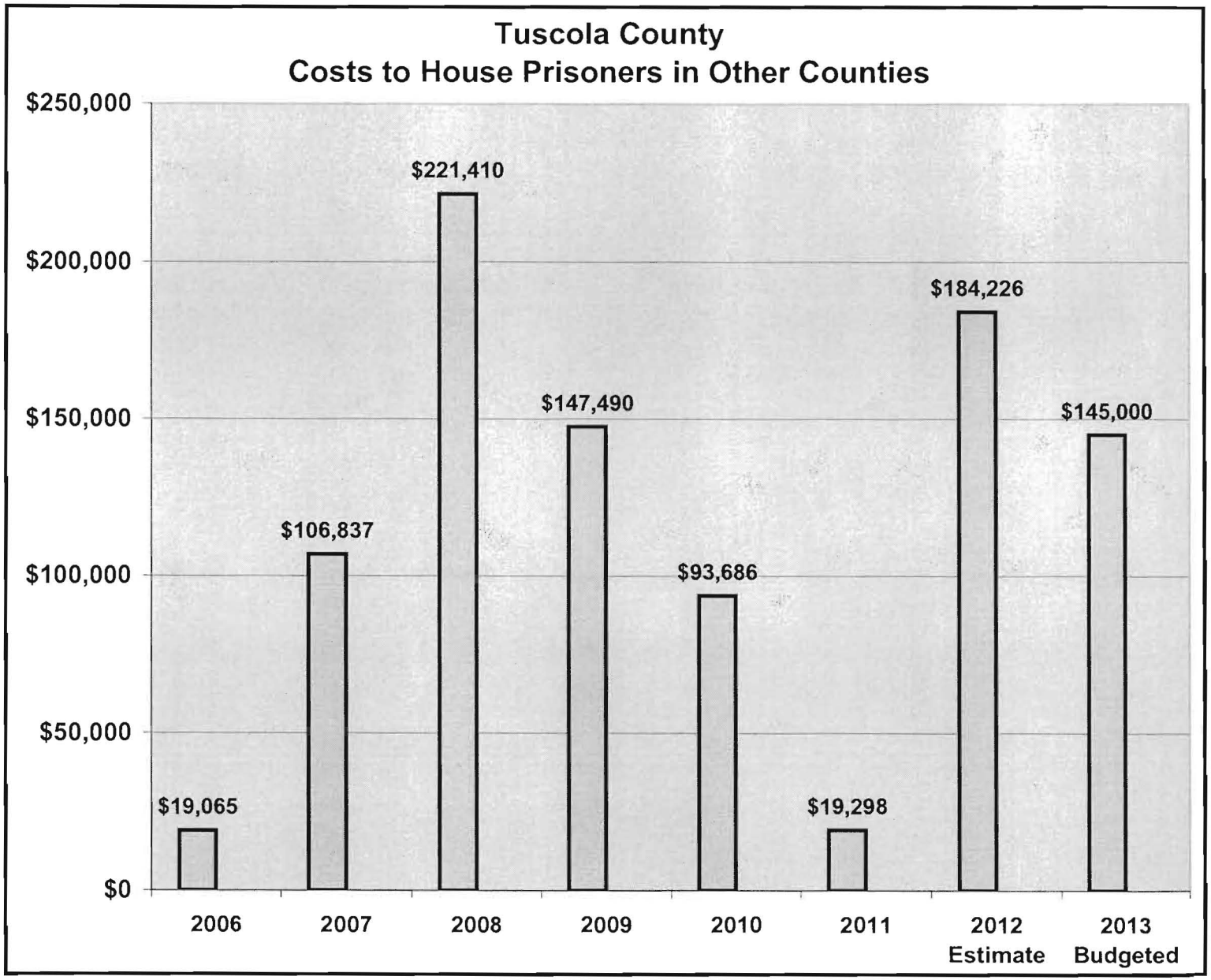
I am requesting authorization to obtain temporary service assistance for up to 16 weeks (4 weeks of training while the HR is in the office plus the 12 weeks of FMLA). The net cost and budget amendment requested is **$4,759** based on the following calculation.

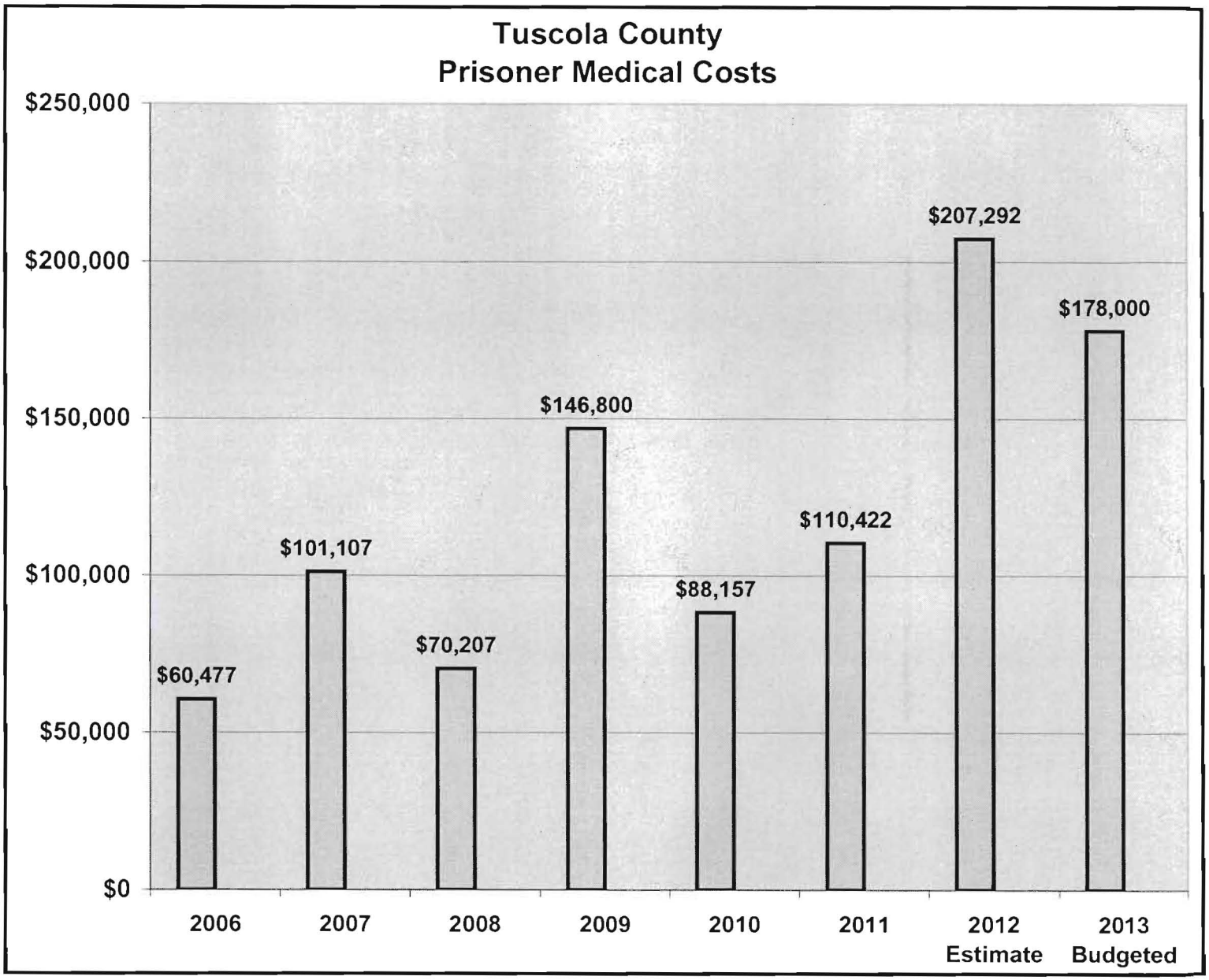
12 weeks of HR budgeted wage/fringe cost =	$13,581
Portion of FMLA paid by County (wages and benefits) =	$ 5,920
Saving by HR being on FMLA leave =	$ 7,661
Net cost for 16 weeks (600 hours) of Cornerstone Services at $20.70 per hour =	$12,420
Saving by HR being on FMLA leave =	$ 7,661
Net budget amendment request =	**$ 4,759**

Thank you.

Michael R. Hoagland
Tuscola County/Controller Administrator
125 W. Lincoln
Caro, MI. 48723
989-672-3700
mhoagland@tuscolacounty.org


Jail Expenditures
$2,400,000
$2,300,000
$2,200,000
$2,100,000
$2,000,000
$1,900,000
$1,800,000
$1,700,000
$1,600,000
$1,500,000
$1,668,921
$1,907,367
$2,056,985
$2,110,117
$2,092,397
$2,060,462
$2,325,975
2006
2007
2008
2009
2010
2011
2012 Proj.
Jail Expenditures


Tuscola County
Costs to House Prisoners in Other Counties
$250,000
$200,000
$150,000
$100,000
$50,000
$0
$19,065
$106,837
$221,410
$147,490
$93,686
$19,298
$184,226
$145,000
2006
2007
2008
2009
2010
2011
2012 Estimate
2013 Budgeted


Tuscola County
Prisoner Medical Costs
$250,000
$200,000
$150,000
$100,000
$50,000
$0
$60,477
$101,107
$70,207
$146,800
$88,157
$110,422
$207,292
$178,000
2006
2007
2008
2009
2010
2011
2012 Estimate
2013 Budgeted

Jail Points of Discussion

Funding Overview

It is important to keep in perspective in making future financial decision that the county has just gone through what may be one of the most difficult financial times in its history. Financial ability has declined over the last several years. Land values have been on a "free fall" along with significant reductions in state funding required to provide state mandated services. The county has had to make major expenditure reductions with the general fund of the county declining from approximately 12.6 million to 11.6 million over the last three year period.

We have been working to improve financial stability. There is hope that wind energy revenue will allow the county to begin strengthening it financial position so that both current operational and capital improvement costs can be met. We still need to determine how much revenue will be gained from wind energy. With the overall county financial position still challenged, jail expansion projects would require a secure funding mechanism not only for construction costs but also for annual operational cost increases.

Capital Improvement Fund

The county capital improvement fund has been used for the annual costs to maintain 14 county buildings. The county has not been able to add monies to the capital improvement fund for the last five years. In a typical year $200,000 is needed just to maintain the current 14 county buildings and grounds. Reserves in the fund have been declining because they have had to be used to pay for the maintenance costs of current county buildings. In 2011, over $500,000 was expended from this fund to solve the office space needs of the county. The reserves in the capital improvement fund declined from approximately 2.1 million in 2007 to 1.2 million in 2012. If transfers from the general fund are not reestablished remaining reserves may be exhausted in only six more years.

Previous Jail Expansion Studies and Implementation

Solutions to jail overcrowding have been studied for many years in Tuscola County. Landmark Inc. conducted jail expansion and renovation studies in 1996 and 2008. It may be useful to review these studies and update cost information to maintain an up-to-date plan as to how jail overcrowding may be solved on a long-term basis.

The 1998 24 bed expansion was accomplished with the assistance of state grant funds which were available at the time. State funding has not been provided since the county was able to capitalize on the funding for this project in 1998. With the financial issues of the state it is unlikely funding for local jail expansions will be provide in the near future.

Budgeted 5 Bed Jail Addition

The 2013 county budget included approximately $88,000 for remodeling that would add 5 more jail beds. A return on this investment of 1.4 years has been estimated. (5 beds X $35 per day to house prisoners in other county jails X 365 days per year = $63,875). Inquiry with the union and Michigan Department of Correction has indicated that these beds can be added without requiring an increase in corrections officers. Recently, the board decided to postpone adding these beds pending further review and discussion of alternatives.

Housing More Tuscola Prisoners in Other County Jails

For 2012, jail operating costs were approximately $2.3 million. Commissioner Kirkpatrick conducted a calculation that based on an average county responsibility of 100 prisoners each

day at $35 per day per prisoner the annual cost to house these prisoners in other county jails would be approximately $1.3 million. At first glance this analysis indicates a considerable savings if prisoners are housed in other counties. However, there are other factors that need to be considered in this analysis. Commissioner Kirkpatrick asked for more information regarding evaluating this concept including discussion with the sheriff and his staff.

The Sheriff has indicated a county jail housing a minimum number of prisoners would still have to be maintained for holding arrested citizens and inmates prior to court appearances. He explained it would require about the same number of corrections officers to operate a minimum inmate jail as an 86 person jail. Even if the number of corrections officer could be reduced by 4 or 5 he explained it would take that many, if not more, to constantly transport prisoners to other county jails and back to the Tuscola jail. The net effect is minimal if any wage/fringe cost savings which is the largest jail line item cost. Another important point that the sheriff stressed is the major logistical and security problems of scheduling and transporting 100 plus prisoners on an on-going basis to multiple jails around the state. He noted there would be considerable safety issues and cost increases with transporting this many prisoners on a daily basis.

Although our current jail is ageing it continues to meet all Michigan Department of Corrections standards. With continued maintenance and upgrades it will continue to be a viable facility for many years. Additionally the current location is strategic in moving inmates to and from all the county court facilities by allowing secure access and limited exposure to the public and greatly reduces opportunities for escape.
Sheriff other points.....????

Community Corrections Advisory Board
The county has had great success in reducing prisoner costs by using day reporting and tether programs. The questions should be asked at future Community Correction meetings if there are other programs or expansion of current programs that could further reduce costs.

Additionally the county work site program, which allows inmates to reduce their sentence by a day for every day of participation, has saved the county many thousands of dollars annually. I will have Deputy Rod Bertsch provide updated figures on the rate of participation so the savings can be calculated.
Maybe an estimate of what these programs already save.....????

Although it is only used when absolutely necessary and on a limited basis there are laws that allow early release of prisoners based on the nature of their crime. The judges of the county have the discretion to decide if early release will be used to alleviate overcrowding situations

Judge Joslyn allowed us to declare jail overcrowding many times in the past. This allowed us to reduce the sentences of non-violent inmates and release them from custody to ease jail overcrowding. His philosophy changed and the current judge with authority for this possibility has declined to use this option.
Sheriff other points.....????

Camp Tuscola Reuse as the County Jail

This facility was a former dormitory for the Caro Regional Center that was remodeled and added on to when a minimum security camp was developed by the Michigan Department of Corrections. It has a rated capacity for 160 minimum security prison inmates. I do not believe it would come close to meeting the safety and sanitation standards, not to mention the security requirements, for a county jail facility. Even if extensive remodeling could make it habitable for all the necessary classifications it would create additional logistical and security issues with the daily movement of inmates to and from the courthouse. Before this should even be given any further consideration it should be inspected by the Jail Services Division of the Michigan Department of Corrections to see if it even comes close to being usable as a jail facility.

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Reasons why this may not be the correct type of facility for county jail needs

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Housing more in other jails:

The $35 per day rate is for food and sleeping space only. Those inmates are still our responsibility. If they act out or become a problem that jail is calling us to come get them.

We only send out those inmates that have no immediate known physical ailments or special needs. The housing agencies are not going to maintain that $35 per day rate if they now have staff on overtime doing hospital guard.

Even as I write this today, Huron County is wondering when we can come get a few of our inmates we have housed there. They are getting close to having too many inmates on site. This kind of shuffle would be constant if all were housed elsewhere.

Our area of responsibility would not be taken down to the few who remain at the Tuscola County Jail. They are still our prisoners no matter where they are sleeping. We are still responsible for the 100+ inmates on our books. Records still must be maintained and updated. Court appearances kept.

We would need new vans – a guess would be 2-3 for transportation.

Any time more than one inmate is transported out of the secure facility it requires 2 corrections officers to accompany them for safety and security of all involved. The threats the officers face are not just from the inmate but others involved. Victims, victim's families, friends of the inmate, inmate family members are all potential threats. Whenever the inmate is taken away from the secure facility the inmate's safety as well as the public safety could be at risk.

A point to remember is that EVERY person who goes to prison FIRST goes through the county jail system. Every murderer, rapist, drug dealer, etc. is in our jails first as they go through the court system. We cannot become complacent even for a minute.

Community Corrections:

Day reporting and the tether programs still require personnel to administer and monitor the programs. For many inmates those options are not even valid as they have no way to pay for the services. After the last meeting with the commissioners Deputy Bertsch and I took a hard look at our inmates in the jail. My question to him was, "Who in our jail would you feel comfortable letting out on day report if it was up to you?" He only shook his head.

Our jail is full of persons committing repeat felony offenses. They have been through the system several times. They have been given treatment options, deferred sentences, and classes while incarcerated. And they just keep coming back. To push them back into the community to merely save bed space, in my opinion, may come back to bite us When these repeat offenders commit another crime and someone gets harmed or worse it will be a hard sell to tell the victims that at least "we saved some money." Some offenders may qualify. Many do not. I would caution the commissioners not to overestimate the number of persons eligible for these programs. I get the feeling they are thinking in numbers larger than may be a reality.

Eventually we are going to be forced to do something with this jail. Maintenance was here again today to repair the heat/cold issues in C1 andC2. This week we had water leaks in C1, the kitchen, the men's locker and the bathroom next to the kitchen.

Penny

Points - our thoughts -

Jail Points of Discussion

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The Sheriff has indicated a county jail housing a minimum number of prisoners would still have to be maintained for holding arrested citizens and inmates prior to court appearances. He explained it would require about the same number of corrections officers to operate a minimum inmate jail as an 80 person jail. Even if the number of corrections officer could be reduced by 4 or 5 he explained it would take that many, if not more, to constantly transport prisoners to other county jails and back to the Tuscola jail. The net effect is minimal if any wage/fringe cost savings which is the largest jail line item cost. Another important point that the sheriff stressed is the major logistical problems of scheduling and transporting 80 plus prisoners on an on-going basis to multiple jails around the state. He noted there would be considerable safety issues with transporting this many prisoners on a daily basis.

Sheriff other points.....????

Although our current facility is old it continues to meet State Dept of Correction standards for county jails. With continued maintenance and upgrades I do not believe it will continue to be a viable structure for many years

Community Corrections Advisory Board

The county has had great success in reducing prisoner costs by using day reporting and tether programs. The questions should be asked at future Community Correction meetings if there are other programs or expansion of current programs that could further reduce costs.

Maybe an estimate of what these programs already save.....???? Road - jail days, evaluation/ treatment saved through work release and day reporting participation.

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Sheriff other points.....????

Camp Tuscola Reuse as the County Jail

.....????

Reasons why this may not be the correct type of facility for county jail needs

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.....

the facility is designed to hold 160 minimum security state DOC inmates. It will not meet current jail standards and there is absolutely no way to fit use it with the very low number of minimum security inmates we current have.

COUNTY JAIL INSPECTION REPORT

Daniel H. Heyns, Director
Michigan Department of Corrections

TUSCOLA COUNTY

County Jail Services Unit

Report Prepared by:

Jeffrey Cook

2012

COUNTY JAIL INSPECTION REPORT
TUSCOLA COUNTY
NOVEMBER 1, 2012

Table of Contents

Scope of Inspection

An inspection of the Tuscola County Jail was conducted on October 24, 2012, by the County Jail Services Unit, Michigan Department of Corrections, as provided for by Act No. 232 of the Public Acts of 1953, as amended, being Section 791.262 of the Michigan Complied Laws.

The inspection was conducted by Jeffrey Cook Correctional Facility Specialist, County Jail Services Unit. The exit conference was conducted with Sheriff Leland Teschendorf and Jail Administrator Lieutenant Penny Turner.

Inspection Objectives

The inspection of the Tuscola County Jail had the following objectives:

1. To determine compliance with the Administrative Rules for Jails and Lockups of 1998, and all applicable statutes for housing inmates in county jails.

2. To provide a document for follow-up and to resolve any areas of noncompliance with the Administrative Rules for Jails.

Background

The Tuscola County Jail was constructed in 1966 with a capacity of 46 beds.

In 1988, renovations increased the capacity to 53 beds.

In 1994, additional renovations increased the rated design capacity to 56 beds.

In 1997, an addition to the jail increased the rated design capacity to 80 beds.

Findings

On the day of our inspection, the Tuscola County Jail was in compliance with all of the Administrative Rules for Jails and Lockups.

(D)

EvansPletkovic
A PROFESSIONAL CORPORATION

Attorneys & Counselors
William N. Evans
Mark J. Pletkovic
Gregory P. Sweda
Melinda L. Evans
Sandra L. Ganos
Diane L. Berkowitz
Michael L. Rutkowski

Of Counsel
Jerome H. Solomon

March 11, 2013

C. Patrick Kaltenbach, Esq.
Braun Kendrick Finkbeiner, PLC
4301 Fashion Square Blvd.
Saginaw, MI 48603-5218

Re: Opinion Letter
Our File: 139-2186

Dear Mr. Kaltenbach:

As you are well-aware, our office represents Thumb Area Dental Clinics, Inc. also known as TADC, in connection with the above-referenced matter. A preliminary draft of the "Contract for Services" has been circulated and I look forward to working with you and your firm to finalize a version that is acceptable by all parties.

In reference to your letter dated February 27, 2013, I have attached an article titled Current Issues in Medicaid Financing - An Overview of IGTs, UPLs, and DSH which does a thorough analysis and explanation of the enhanced Medicaid reimbursement process and intergovernmental transfer of funds procedure. After reading the above-attached documents and also other various legal authority, it is our legal opinion that IGTs and related contracts with said counties from a clinic such as TADC is a permissible use under the Medicaid Act.

The Federal statues relied upon are as follows:

- *42 USC §1396a*
- *42 CRF §433.50, 433.52, 433.54, 433.57, 433.66, 433.67*

Furthermore, as I am sure you are well-aware, other agencies have been working under a similar model for quite sometime and although that does not automatically

26125 Woodward Avenue
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make it permissible, I have no knowledge of them being reported for any type of fraud or abuse of the Medicaid system.

Lastly, particular to our situation, billings will happen real-time at the Medicaid standard rate. In addition, every quarter each County and TADC, per the County's "contract for services," will submit funds to Medicaid for enhanced reimbursement. This financial arrangement is being used currently across the United States and, in my legal opinion, is not in violation of any kick-back regulations.

If you have any questions regarding the above or wish to discuss this matter further, please feel free to contact the undersigned.

Very truly yours,

Michael L. Rutkowski

Michael L. Rutkowski

MLR/kam
Enclosure

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

April 2004

Current Issues in Medicaid Financing – An Overview of IGTs, UPLs, and DSH

By David Rousseau and Andy Schneider

Since its enactment in 1965, Medicaid has been a joint venture between the states and the federal government. While each state administers its own Medicaid program within broad federal guidelines, the federal government provides the majority of the program's financing. As a result, Medicaid is not only one of the largest budget items in each state, it is also the single largest source of federal grant funds to the states. This shared financing structure, with its guarantee of federal matching funds for state expenditures for beneficiaries, is the foundation of the individual entitlement to coverage through which Medicaid pays for health and long-term care services for more than 50 million our nation's sickest and poorest individuals.[1]

As might be expected, shared financing has at times produced tension over each level of government's appropriate share of the cost of the Medicaid program. By statutory formula, the federal government pays between 50 and 77 percent of all the costs incurred by states in purchasing covered services on behalf of Medicaid beneficiaries. Matching rates vary by state, with states that have lower per capita incomes receiving higher federal matching rates. On average, the nominal federal share is 57 percent.

States have only recently begun to emerge from one of the worst fiscal situations they have faced since World War II.[2] At the same time, the federal government has increased its scrutiny of several controversial mechanisms states have employed in recent years to finance their share of Medicaid expenditures. The purpose of this paper is to explain briefly the mechanisms at issue and present the most recent available data on the states most affected. As discussed below, although these transactions involve large sums, they represent only a small part of a much larger Medicaid program that directly benefits over 50 million low-income Americans and the health care providers that serve them. Similarly, the challenge to Medicaid financial management extends beyond these transactions.[3]

1330 G Street NW, Washington, DC 20005
Phone: 202 347 5270, Fax: 202 347 5274
Website: www.kff.org

Background and Overview

The financing mechanisms in question involve highly technical issues relating to IGTs (intergovernmental transfers), UPLs (upper payment limits), DSH (disproportionate share hospital) payments, and provider taxes. In and of themselves, all of these are legal under federal law and regulation and do not change the nominal federal share. However, in certain configurations, transactions involving IGTs, UPLs, and DSH payments are designed to increase the federal share of Medicaid costs above a state's statutory matching rate. These transactions are problematic for two reasons. First, they raise the federal matching rate without authorization by the Congress through a change in the matching formula.[4] And second, in some cases, states apply these additional federal funds to purposes other than health or long-term care services for low-income residents.[5]

Federal and state disagreements about the use of such mechanisms are not new. As disputes have surfaced periodically over the last two decades, however, Congress and the Administration have addressed and resolved each of these debates without fundamentally altering the basic federal-state matching structure. Figure 1 on the next page provides a timeline of these federal responses.

Several events in 2004 have precipitated the latest iteration of these disagreements. First, the Bush Administration's FY 2005 budget proposes to achieve $9.6 billion in savings to the federal government over the next 5 years by restricting the use of certain IGTs and limiting payments to state and local hospitals and nursing homes to the cost of services provided to Medicaid patients.[6] According to the Administration's budget, "Medicaid's open-ended financing structure encourages efforts to draw down Federal matching funds in any way possible, some of which are not appropriate. These financing practices undermine the Federal-State partnership and jeopardize the financial stability of the Medicaid program."[7] The Senate Budget Committee directed a $3.4 billion reduction in federal Medicaid spending over 5 years in its FY 2005 budget resolution, attributing these savings to unspecified "waste and abuse in the system."[8] Additionally, the controversy has been fueled by a proposal by the Centers for Medicare and Medicaid Services (CMS) to modify an obscure reporting form (CMS-37) in order to require states to identify more fully the revenue sources used to pay their share of Medicaid expenditures.[9] This change has been seen by some as presaging a fundamental shift in the current federal-state matching arrangement, with the federal government asserting a right through its regulatory authority to prospectively approve state Medicaid budgets and to subject federal matching payments to prior approval, which is unprecedented in the program's nearly 40 year history.[10] The Administration has indicated it plans to pursue such a change, after consultation with the governors and appropriate time for public comment.[11]

Figure 1
A Summary Timeline for Federal Action on DSH, IGTs, Provider Taxes, and UPLs

1981	Congress requires states to make additional payments to DSH hospitals for inpatient services (Omnibus Budget Reconciliation Act of 1981)
1987	Congress establishes a minimum federal standard for qualifying as a DSH hospital (Omnibus Budget Reconciliation Act of 1987) CMS (then HCFA) issues UPL regulation limiting aggregate payments to state-operated hospitals and nursing facilities and all other hospitals and NFs (52 Fed. Reg. 28141, July 28, 1987)
1991	Congress (1) establishes detailed rules for provider taxes used to generate revenues as state share of Medicaid spending, (2) prohibits CMS from restricting IGTs of state or local tax revenues, and (3) limits DSH spending in each state to 12 percent of total Medicaid spending (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991)
1993	Congress imposes facility-specific ceilings on the amount of DSH payments states may make to DSH hospitals (Omnibus Budget Reconciliation Act of 1993)
1997	Congress specifies and phases down over FY 1997 – FY 2002 allotments of federal DSH funds for each state (Balanced Budget Act of 1997)
2000	Congress (1) increases state-specific allotments of federal DSH funds for FY 2001 and FY 2002, and (2) requires CMS to issue final regulations applying UPLs to providers owned or operated by local governments and allowing for a transition period of up to 8 years (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000)
2001	CMS issues final regulations establishing UPLs for local public providers and transition periods (66 Fed. Reg. at 3154, 3173, January 12, 2001)
2003	Congress increases state-specific allotments of federal DSH funds for FY 2004 by 16 percent (Medicare Prescription Drug, Improvement, and Modernization Act of 2003)

IGTs

As the name implies, IGTs, or intergovernmental transfers, are transfers of public funds between governmental entities. The transfer may take place from one level of government to another – e.g., counties to states – or within the same level of government, from one agency to another – e.g., from a state university hospital to a state Medicaid agency. The federal Medicaid statute expressly recognizes the legitimacy of IGTs involving tax revenues.[12] IGTs made by

localities from their own tax revenues to help fund a state's Medicaid program are a legitimate way for a state to pay its share of Medicaid spending. Current law stipulates that no more than 60 percent of the state share may be from local funds.[13] While some states require their localities to contribute toward the cost of Medicaid, only New York even remotely approaches this limit as it requiring its counties to contribute 50 percent of the state share.[14]

The controversy surrounding IGTs centers around what qualifies as the state share of Medicaid spending. Under current law and regulation, the state share of Medicaid spending must consist of public funds.[15] These funds may not be federal funds, unless, as in the case of the federal share of the tobacco settlement payments, they are expressly authorized to be used as the state share.[16] The controversy arises when the funds involved in these IGTs come from specific types of provider taxes or donations, or when they are the means through which UPL arrangements are implemented (see below).

UPLs

While IGTs relate to what qualifies as the state share of Medicaid spending, UPLs, or upper payment limits, have to do with the amounts state Medicaid programs can pay to providers for covered services. These limits are creatures of federal regulations, not statute.[17] Current UPL regulations limit Medicaid payments, in the aggregate, for inpatient services provided by three classes of hospitals, three classes of nursing homes, three classes of intermediate care facilities for the mentally retarded (ICFs/MR), and for outpatient services provided by three classes of hospitals and clinics. In each case, the provider classes are defined on the basis of ownership or operation by the state, by localities, and by private entities.[18]

The limit applied by UPLs is the estimated amount that would be paid for Medicaid-covered services under Medicare payment principles. This limit applies to the entire class of providers (e.g., all private hospitals in a state); thus, an individual facility could be paid more by Medicaid than what Medicare would have paid so long as at least some other facilities in the same class were paid sufficiently less to offset the overpayment. These limits went into effect on March 13, 2001; however, some states have qualified for "transition periods" through as long as 2008 that exempts them from these regulations.

The key to UPL arrangements prior to the 2001 regulations was to (1) create a gap between the upper payment limit and regular Medicaid reimbursements by underpaying private facilities relative to Medicare rates; (2) then to make a payment or payments to public facilities in the amount of this gap; (3) to claim federal matching funds on this excess payment; (4) and finally, to return some or all of the funds from the public facilities to the state treasury though an IGT.

For example, assume a state has 10 nursing facilities – 9 private and 1 owned and operated by a county. Assume further that each facility has 100 Medicaid residents, and that the state pays a hypothetical Medicare rate of $150 per resident per day to the county facility, but only 2/3 of the Medicare rate, or $100 per resident per day, to each of the private facilities. Prior to the 2001 regulations, the UPL applied to all 10 facilities, yielding an aggregate upper limit of $150,000 ($150 times 1000 residents). However, because the state had only paid $90,000 to the private facilities ($100 times 900 residents) and $150,000 to the county facility ($150 times 100 residents), it had generated a gap of $45,000 under its UPL. The state could then make a supplemental payment from state funds to the county facility of $45,000. If the state's federal matching rate were 50 percent, the payment would yield $22,500 in federal matching payments. The county facility could then transfer the entire amount back to the state through an IGT. As a result, the state would have effectively generated an additional $22,500 in new federal dollars without any actual outlay of its own funds. This transaction could also be structured to rely entirely on county funds, with an IGT of $45,000 from the county to the state prior to the state's supplemental payment of $45,000 to the county. In this variation, the county gets its money back, and the state draws down $22,500 in federal matching funds on the $45,000 payment to the county and retains the federal funds for its own use.

The 2001 regulations apply the UPL separately to state, private, and county-owned facilities. Therefore, after March 2001, the $45,000 aggregate gap in payments to private facilities described in the example above could only be used to make supplemental payments to private facilities. Because the county facility is paid at Medicare rates, there is no gap under the UPL for this class of providers, and the state could not generate any additional federal funds from supplemental payments to these facilities. For this reason, the 2001 federal regulations greatly limited the ability of states to draw down additional federal funds from such transactions.

Because those states that had received federal approval to conduct these transactions during the 1990s had come to rely on them to help fund their health care programs, the federal government allowed these states to phase out their UPL payments over transition periods lasting as long as 8 years. According to the Administration's FY 2005 budget, the federal cost of UPL arrangements over the next 5 years is $9.2 billion.[19] While this amount of spending is significant, it represents less than one percent of projected federal Medicaid spending over that period.[20] The General Accounting Office, among others, has questioned the validity of several of these transition periods.[21]

DSH

DSH, or "disproportionate share" hospitals are hospitals that serve a large number of Medicaid and low-income uninsured patients. Under federal law, state

Medicaid programs must "take into account the situation of" these hospitals in setting payment rates for inpatient services.[22] This requirement has come to mean making a payment supplemental to the reimbursement a hospital would normally receive under the Medicaid program for inpatient services. The hospitals qualifying for these additional payments are generally determined by each state (subject to federal minimum standards), and the amount of additional payments made to each facility is set by each state (subject to federal maximum limits). In many states, these DSH payments have been crucial to the financial stability of "safety net" hospitals.[23] Federal DSH payments are estimated to total $8.2 billion in FY 2004.[24]

While states have considerable discretion in determining the amount of DSH payments to each DSH hospital, their discretion is bounded by two caps -- one at the state level, and the other at the facility level. At the state level, the total amount of federal funds that each state can spend on DSH payments to all of its DSH hospitals each fiscal year from FY 1997 on has been fixed in statute.[25] Congress recently increased these state-specific DSH allotments for FY 2004 by 16 percent across-the-board in the Medicare drug legislation at a federal cost of $6.4 billion over the next ten years.[26] At the facility level, the total amount of Medicaid DSH payments that a state can make to an individual hospital is limited to 100 percent of the costs incurred by a hospital for serving Medicaid and uninsured patients for which it has not been compensated by Medicaid.[27] For the two state fiscal years beginning after September 30, 2002, Congress raised this limit to 175 percent of such uncompensated costs.[28]

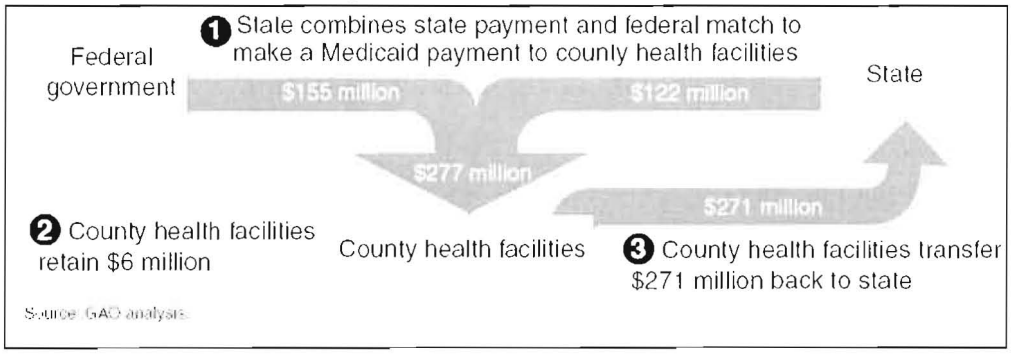
Provider Taxes

The revenues that states use as their share of Medicaid costs come from a variety of sources, including income, sales, property, and estate taxes. States may also use revenues from the imposition of fees, assessments, or other types of taxes on health care providers, but only if the tax meets detailed requirements specified in federal law and regulation. These laws and regulations resulted, in part, from widespread use of licensing fees and other specific taxes in the 1980s that effectively lowered the real state share of Medicaid spending, increased provider revenue, and increased federal Medicaid outlays. As shown previously in Figure 1, Congress acted in 1991 to regulate the use of these taxes. Under these new requirements, if 85 percent or more of the burden of a tax falls on health care providers, the tax must be imposed uniformly on all non-Federal, nonpublic providers in the class (e.g., hospitals, nursing facilities, etc.) and providers paying the tax must not be held harmless for the costs of the tax through offsetting payments or credits.[29] In the past few years, as revenue pressures have mounted, states have turned to revenues from taxes on hospitals, nursing homes, and managed care organizations to help finance their share of Medicaid program costs.[30] Because these taxes are broad- based and the taxed amounts are not directly returned to the providers, they do not violate the current federal regulations regarding such taxes.

Use of IGTs, UPLs, and DSH to Increase a State's Effective Matching Rate

In and of themselves, IGTs, UPLs, and DSH payments are not improper. In fact, as noted above, they are expressly authorized (and in the case of DSH) required by federal Medicaid statute or regulations. However, they can be (and have been) combined in such a way as to increase a state's federal Medicaid matching rate. For example, Figure 2 below presents one state's use of these mechanisms to increase federal Medicaid matching funds with no outlay of state dollars.[31] As described in a recent General Accounting Office report, a state first made Medicaid payments totaling $277 million to certain county health facilities where aggregate Medicaid spending was bellow the upper payment limit based on Medicare payment levels. These payments included $155 million in federal funds at a matching rate of 56 percent (step 1). Immediately upon receiving these funds, the county health facilities transferred through an IGT all but $6 million of the excess payments back to the state, which retained $271 million for a net gain of $149 million in new federal funding (steps 2 and 3).

Figure 2: General Accounting Office's Example of One State's Arrangement to Increase Federal Medicaid Payments



Similarly, some states have used their DSH programs to make unusually large payments to government-owned facilities, which then used IGTs to return the bulk of the federal and state funds to the state treasury. A recent survey of DSH and UPL financing mechanisms in 34 states found, however, that in 2001 most of the gains under DSH accrued to providers, while under UPL programs the bulk of the gains were returned to the state treasury. Nevertheless, such transactions involving both UPL and DSH were estimated to have increased the average federal matching rate by three percentage points in the 29 states that provided data in 2001.[32]

State-by-State Distribution of IGTs, UPLs, and DSH

There is no national public database on the use of IGTs in Medicaid. There are, however, data available to the public on the expenditures under UPLs and for DSH hospitals. These data, while limited, show that the current controversy over UPLs affects just under half the states.

On October 8, 2003, the CMS Administrator testified before a House Subcommittee that "States often find ways to use IGTs to avoid paying the statutory match rate and effectively shift a larger portion of Medicaid costs to the Federal government."[33] While the Administrator did not present any state-by-state data at that time, in response to Member questions, CMS subsequently produced the data presented in Table 1 below.

Table 1: Estimated Total UPL Transition Payments

(as of 1/22/2004)

State	UPL Type[1]	Transition Period	Total Payments	Comments[2]
Alabama	IH	5	--	May not qualify for Transition
	OH	5	--	May not qualify for Transition
	NF	5	--	May not qualify for Transition
Alaska	IH	2	$36,851,234	
Arkansas	OH	2	$56,500,000	
California	IH	8	$3,853,398,807	
Georgia	IH	5	--	May not qualify for Transition
Illinois	OH	8	$981,077,623	
	IH	8	$3,410,932,473	
Iowa	NF	2	$148,923,590	
Kansas	NF	2	$46,854,572	
Louisiana	NF	2	$1,166,666,296	
Michigan	OH	1	--	UPL calculations not complete
	OH	5	--	UPL calculations not complete
	NF	5	$2,262,265,250	
Missouri	IH	1	--	
	NF	2	$433,014,424	
Nebraska	NF	8	$363,772,160	
New Hampshire	NF	5	$82,070,559	
New Jersey	NF	2	$920,000,000	
New York	NF	5	$2,809,851,503	
North Carolina	IH	5	$0	Did not qualify for Transition
	OH	5	$0	Did not qualify for Transition
North Dakota	NF	5	$128,312,825	
Oregon	NF	5	$187,869,560	
Pennsylvania	NF	8	$6,479,520,523	
South Dakota	NF	2	$90,800,000	
Tennessee	NF	2	$199,261,426	
Virginia	NF	1	$477,405,016	
Washington	IH	1	--	UPL calculations not complete
	NF	5	$493,627,778	
Wisconsin	NF	2	$1,014,868,858	
	NF	8	$122,839,917	
Total (24 States)	33		$25,766,684,393	

[1] IH = inpatient hospital services; OH = outpatient hospital services; and NF = nursing facility services.

[2] CMS indicated that some programs may not qualify under existing federal regulations for the transition period indicated.

Source: CMS Administrator Tom Scully's written response to questions before the House Energy and Commerce Health Subcommittee on October 13, 2003, submitted Friday, February 13, 2004.

As shown in Table 1, CMS has preliminarily determined that 24 states may qualify for transition periods under existing UPL regulations and that the estimated total computable amount of funds (federal and state share) each state will receive over their entire transition period for each type of UPL arrangement (inpatient hospital, outpatient hospital and nursing facility) will total more than $25 billion. Transition periods for 1-year and 2-year transition states have expired. However, CMS indicated that four states with 2-year UPL transition periods – Arkansas, Kansas, Louisiana, and Missouri – have spent beyond what CMS believes was their allowable UPL transition amount. All of the 5-year and 8-year UPL transition periods remain active.

In December, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173). Title X of the MMA provides for a one-time increase in state-specific Medicaid DSH allotments of 16 percent across the board in FY 2004.[34] As shown in Table 2 on the next page, this change increased total federal DSH allotments from $8.7 billion in FY 2003 to $10.1 billion in FY 2004. Table 2 also demonstrates the large variation in DSH spending as a percent of total Medicaid spending in each state. DSH accounted for 6.4% of Medicaid spending nationally in 2002, ranging from less than 1% of total Medicaid spending in Wyoming and Montana to more than 17% of spending in Louisiana and New Hampshire.[35]

Conclusion

No figures are available on the total amount of IGTs used by states as their share of Medicaid spending. The amount of federal DSH and UPL payments in FY 2004 are estimated to total $13.4 billion, or 8 percent of federal Medicaid spending.[36] This is a significant commitment of federal resources and the federal government must ensure accountability for the use of these funds, as well as the remaining 92 percent of federal Medicaid funds.[37] A recent report prepared for the Kaiser Commission on Medicaid and the Uninsured by a former federal Medicaid official identified some significant improvements that CMS could undertake within Medicaid's existing financing structure to improve financial management and promote accountability for use of federal funds.[38] Such changes undertaken to improve accountability should both support the program's existing health and long term care coverage goals and help it meet the many challenges it faces, including the growth in the number of low-income uninsured Americans,[39] and the rapid increases in the cost of prescription drugs and other health and long-term care services.[40] Moreover, states continue to face significant budget shortfalls because of declining tax revenues, and will be even more challenged as the temporary fiscal relief provided by the Jobs and Growth Act of 2003 expires at the end of June 2004.[41]

Table 2

Federal Medicaid DSH Allotments

State	DSH as % of Total Medicaid Spending 2002	(Federal Allotments in Millions) Pre-MMA 2003	Post-MMA 2004	Post-MMA 2005
United States	**6.4%**	**$8,748**	**$10,148**	**$10,187**
Alabama	12.0	250	290	290
Alaska*	2.7	9	11	12
Arizona	2.5	82	95	95
Arkansas*	0.6	19	22	26
California	5.0	890	1,033	1,033
Colorado	6.9	75	87	87
Connecticut	6.7	162	188	188
Delaware*	0.5	4	5	5
District of Columbia	3.9	32	38	38
Florida	3.9	162	188	188
Georgia	6.8	218	253	253
Hawaii	--	--	--	--
Idaho*	1.3	7	9	10
Illinois	4.2	175	203	203
Indiana	8.9	174	201	201
Iowa*	1.1	18	20	24
Kansas	2.2	33	39	39
Kentucky	5.2	118	137	137
Louisiana	17.3	631	732	732
Maine	3.5	85	99	99
Maryland	3.7	62	72	72
Massachusetts	7.9	248	287	287
Michigan	5.3	215	250	250
Minnesota*	1.3	33	39	45
Mississippi	6.5	124	144	144
Missouri	9.9	385	446	446
Montana*	0.1	5	6	7
Nebraska*	0.8	13	15	17
Nevada	9.4	38	44	44
New Hampshire	17.7	132	153	153
New Jersey	15.5	523	606	606
New Mexico*	0.7	9	11	12
New York	7.8	1,304	1,513	1,513
North Carolina	6.6	240	278	278
North Dakota*	0.5	4	5	6
Ohio	6.7	330	383	383
Oklahoma*	1.0	16	19	22
Oregon*	0.9	20	24	27
Pennsylvania	6.4	456	529	529
Rhode Island	6.4	53	61	61
South Carolina	11.6	266	308	308
South Dakota*	0.2	5	6	7
Tennessee	--	--	--	--
Texas	10.4	776	901	901
Utah*	1.2	9	10	12
Vermont	4.3	18	21	21
Virginia	4.7	71	83	83
Washington	6.9	150	174	174
West Virginia	5.2	55	64	64
Wisconsin*	1.2	42	49	57
Wyoming*	0.1	0	0	0

* "Low-DSH State" These states continue to receive 16% increases through FY 2008.

NOTE: MMA refers to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173). DSH provisions are contained in Title X, Section 1001 of the MMA. 2002 data represent actual DSH spending as a percent of total program spending.

SOURCE: 2002 data from KCMU and Urban Institute analysis of CMS-64 data. 2003 and 2004 allotments are from Fed Reg. Vol 69, No. 59., p. 15861 and p. 15863, March 26, 2004. 2005 allotments are estimates prepared by KCMU, 2004.

Medicaid's current federal-state matching structure enables states and the federal government to respond flexibly and quickly to changes in the health care system, to emerging public health threats, and to changes in the location or needs of the nation's low-income population.[42] As attempts are made to strengthen program integrity and accountability by curtailing or modifying the use of IGTs, UPLs, DSH, or provider taxes, care should be taken to do so in a way that does not jeopardize the many benefits the program brings to low-income Americans, states, the local health safety net, and the nation's health care system as a whole.

Endnotes

[1] For more on Medicaid financing issues, see Wachino, Schneider, and Rousseau, "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds," The Kaiser Commission on Medicaid and the Uninsured (January 2004).
[2] See Boyd and Wachino, "Is the State Fiscal Crisis Over? A 2004 State Budget Update," The Kaiser Commission on Medicaid and the Uninsured (January 2004).
[3] See Thompson, P, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," The Kaiser Commission on Medicaid and the Uninsured (February 2004).
[4] Researchers at the Urban Institute have estimated that in state fiscal year 2001 these transactions increased the average federal matching rate by three percentage points in the 29 states for which they had data; see Coughlin et al., "States' Use of Medicaid UPL and DSH Financing Mechanisms," Health Affairs, Vol. 23, No. 2, March/April 2004. See also, GAO, "Major Management Challenges and Program Risks: Department of Health and Human Services," (January 2003), GAO-03-101, pp. 27- 29.
[5] GAO, "Medicaid: Improved Federal Oversight of State Financing Schemes is Needed," (February 2004), GAO-04-228, p. 1.
[6] Centers for Medicare and Medicaid Services FY 2005 Budget in Brief (January 2004), p. 66.
[7] OMB, The Budget for Fiscal Year 2005, p. 149.
[8] Committee Print, Concurrent Resolution on the Budget – Fiscal Year 2005 (March 5, 2004), p. 28, available at www.senate.gov/~budget/republican/pressarchive/CommitteePrint2005.pdf. The House Budget Committee's report was silent on the issue of Medicaid cuts related to "waste and abuse."
[9] 69 Fed. Reg. 922 (January 7, 2004).
[10] Miller, V, "Cash Ceilings May be Placed on Medicaid Drawdowns," Federal Funds Information for States, Issue Brief 04-02 (February 4, 2004).
[11] Pear, Robert. "Bush to Revisit Changes in Medicaid Rules, The New York Times (February 23, 2004).
[12] Section 1903(w)(6) of the Social Security Act, 42 U.S.C. 1396b(w)(6).
[13] Section 1902(a)(2) of the Social Security Act, 42 U.S.C. 1396a(a)(2).
[14] CMS Survey of Regional Medicaid Offices, April 2001, as cited by the New York State Association of Counties.
[15] 42 CFR 433.51
[16] Kaiser Commission on Medicaid and the Uninsured, The Medicaid Resource Book (July 2002), p. 105.
[17] 66 Fed. Reg at 3154, 3173 (January 12, 2001) and 67 Fed. Reg at 2610 (January 18, 2002).
[18] See Schneider and Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing," The Kaiser Commission on Medicaid and the Uninsured (February 2002).
[19] Budget of the United States FY 2005, Analytical Perspectives, Table 24-5.
[20] Budget of the United States FY 2005, Analytical Perspectives, Table 24-1.
[21] See GAO, "Medicaid: Improved Federal Oversight of State Financing Schemes is Needed," (February 2004), GAO-04-228.
[22] Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 USC 1396a(a)(13)(A)(iv).
[23] Institute of Medicine, America's Health Care Safety Net: Intact but Endangered (2000), pp. 87-102, www.nap.edu.
[24] CBO, March 2004 Medicaid Baseline, 3/3/2004.
[25] Section 1923(f) of the Social Security Act, 42 U.S.C. 1396r-4(f).
[26] Informal HHS estimates from November 2003. It should be noted, however, that a letter from CBO Director Douglas Holtz-Eakin to the Honorable Bill Thomas, Chairman of the House Committee on Ways and Means, dated November 20, 2003, estimated the federal impact of the MMA's DSH provisions at $3.0 billion over ten years, apparently assuming that states will not draw down their full allotments over the next decade.
[27] Section 1923(g) of the Social Security Act, 42 U.S.C. 1396r-4(g).
[28] See BIPA (P.L. 106-554), section 701(c); in California the 175 percent limit applies indefinitely.

[29] Section 1903(w) of the Social Security Act, 42 U.S.C. 1396b(w).
[30] See Smith et al. "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004 – Results from a 50 State Survey," The Kaiser Commission on Medicaid and the Uninsured (September 2003).
[31] General Accounting Office, "Major Management Challenges and Program Risks – Department of Health and Human Services", January 2003, p. 27, GAO-03-101.
[32] Coughlin et al., 2004.
[33] Testimony of Thomas Scully, Administrator, Centers for Medicare & Medicaid Services before the Subcommittee on Health of the House Committee on Energy and Commerce (October 8, 2003), p. 2.
[34] MMA also contained special provisions for the 16 states with DSH expenditures between 0% and 3% of total (state and federal) Medicaid spending in FY 2000, defined as "low DSH states." The allotment for these states increases by 16% each year from FY 2004 through FY 2008, and by the CPI-U thereafter.
[35] Both Hawaii and Tennessee do not have separate DSH allotments as they have incorporated these into their section 1115 Medicaid waiver programs.
[36] CBO, March 2004 Medicaid Baseline, 3/3/2004.
[37] See CBO, March 2004 Medicaid Baseline, 3/3/2004, and Thompson, P, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," The Kaiser Commission on Medicaid and the Uninsured (February 2004).
[38] Thompson, P, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," The Kaiser Commission on Medicaid and the Uninsured (February 2004).
[39] See "The Uninsured: A Primer – Key Facts About Americans Without Health Insurance," The Kaiser Commission on Medicaid and the Uninsured (December 2003).
[40] See Holahan and Bruen, "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" The Kaiser Commission on Medicaid and the Uninsured (September 2003).
[41] See Smith et al. "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," The Kaiser Commission on Medicaid and the Uninsured (January 2004).
[42] See Wachino, Schneider, and Rousseau, "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds," The Kaiser Commission on Medicaid and the Uninsured (January 2004).

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(E)

TUSCOLA COUNTY
BOARDS & COMMISSIONS APPOINTMENT APPLICATION

Please return this questionnaire to the County Clerk's Office, Attention: Appointments Division, 440 N. State St., Caro MI 48723; by email to appoint@tuscolacounty.org ; or by fax at (989) 672-4266 Please submit your resume with this application.

Boards/Commissions for which you would like to be considered: Planning Commission

Boards/Commissions for which you would like to be considered:

First Name* Louis Middle Initial* C Last Name* Smallwood

Have you ever used, or have you ever been known by any other name? ☒ Yes ☐ No

If yes, provide names and explain: Lou Smallwood - Nickname

Home Address 1003 Day Road City Vassar Zip 48768

Township Tuscola County Tuscola

Employer Name: Mid-Michigan Restaurant Consultants

Employer Address 1003 Day Road City Vassar Zip 48768

Position Title President and Owner

Work Number* (10 digit) 1 989 823 2120 Home Number* (10 digit) 1 989 823 2120 Cell Number (10 digit) 1 989 863 0016

Email louis.smallwood@sbcglobal.net (email is the preferred method of contact, please provide if available)

Are you a United States Citizen? ☒ Yes ☐ No

EDUCATION (Include degree and dates; if answered in full on your attached resume, please indicate):

SEE Resume

EMPLOYMENT EXPERIENCE (if answered in full on your attached resume, please indicate):

See Resume

Do you hold any professional licenses? If so, please include numbers:

None.

What special skills could you bring to this position?

40 years experience as a business msn.

Previous government appointments: None.

Please provide us with the names of your:

State Senator Mike Green State Representative Terry Brown

County Commissioner

The following **optional** information is elicited in order to ensure that this administration considers the talent and creativity of a diverse pool of candidates. In addition, specific backgrounds or qualifications are legally required for appointment to some boards and commissions. You may, therefore, wish to provide this information in order to ensure that you are considered for relevant boards and commissions.

Age 57 Political Affiliation Republican Military Service None

Spouse or Partner's Name Mary

CONSENT AND CERTIFICATION

I, Louis Smallwood (please print name), hereby certify that the information contained in this application is true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any misrepresentation, falsification or omission of information on this application or on any document used to secure employment shall be grounds for rejection of this application or immediate discharge if I am employed, regardless of the time elapsed before discovery.

Signed By

Lou Smallwood
1003 Day Rd.
Vassar, MI 48768
989 823 2120
louis.smallwood@sbcglobal.net

Executive Summary:

- Demonstrated excellent leadership skills.
- Major strengths in planning, problem solving and communication.
- Proficient in leading a diverse team.
- Excels in directing and leading others to produce desired results.
- Skilled at encouraging others and developing rapport.
- Adept at both oral and written communication. Interact effectively with individuals of all levels.
- Work well in a high pressure environment.
- Self-motivated and assertive.
- Demonstrated record of achieving results including sales building, cost control, profitability and Guest satisfaction.

Skills:

Strategic planning
Leadership
Management
Teamwork
Manpower planning
Training and development
Guest service
Sales building
Cost control
Profitability

Employment:

Mid-Michigan Restaurant Consultants — Vassar, MI
President/Owner — 2011 to 2013

Team Schostak Family Restaurants — Livonia, MI
Director of Operations — 2001 to 2011

- Executed daily operations of 24 Burger King Restaurants.
- Trained and managed 3 District Managers.
- Was instrumental in sales growth, cost control, profitability, management staffing, training, development and retention.
- Approved hiring and discharging of personnel.

Cheers Inc. San Antonio, TX
Chief Operating Officer

Whataburger of El Paso El Paso, TX
President and Chief Operating Officer

Taco Cabana Inc. San Antonio, TX
Senior Vice President for Operations

Burger King Corporation Miami, FL
Operations Vice President

Education: University of Michigan Graduate School of Business Administration

- Finance for the non-Financial Manager
- Financial Analysis, Planning and Control
- Strategy Formulation and Implementation

Saginaw Valley State University

(F)

Mike Hoagland

From: Brian Neuville [briann@hdc-caro.org]
Sent: Tuesday, March 12, 2013 3:36 PM
To: mhoagland@tuscolacounty.org
Subject: Tuscola County Senior Advisory Council

Mike,

We currently have a vacancy on the Tuscola County Senior Advisory Council for the seat vacated by Tom Kern. The county can appoint a person to this position that is or is not a commissioner. Please let me know who (contact information) the county appoints a person to fill the seat so we can send the pertinent meeting information to them. Hope all is going well for you.

Thanks,
Brian

Facility and Grounds Maintenance Schedule and Cost Estimates

	1 to 5 Years	6 to 10 Years	10 to 15 Years	16 to 20 Years	Total
1. Annex					
Roof Replacement		$20,000			$20,000
Parking Lots Resurfacing		$15,000			$15,000
Parking Lots Sealing	$6,000	$6,000	$6,000	$6,000	$24,000
Tuckpointing		$6,000			$6,000
Window Replacement			$13,000		$13,000
Painting	$5,000	$5,000	$5,000	$5,000	$20,000
Remodeling				$100,000	$100,000
Furnace/Air Conditioning-Repair/Rep			$20,000		$20,000
Sidewalks				$10,000	$10,000
Plumbing					$0
Electrical Upgrading					$0
Floor Covering		$10,000		$10,000	$20,000
Miscellaneous					$0
Total Annex	**$11,000**	**$62,000**	**$44,000**	**$131,000**	**$248,000**
2. Courthouse					
Roof Replacement				$50,000	$50,000
Parking Lots Resurfacing					$0
Parking Lots Sealing					$0
Tuckpointing	$15,000	$30,000	$15,000	$30,000	$90,000
Window Replacement				$100,000	$100,000
Painting	$10,000	$10,000	$10,000	$10,000	$40,000
Remodeling		$100,000			$100,000
Furnace/Air Conditioning-Replace		$999,999			$999,999
Sidewalks		$6,000			$6,000
Plumbing		$100,000			$100,000
Electrical Upgrading					$0
Floor Covering	$10,000	$10,000	$10,000	$10,000	$40,000
Miscellaneous	$7,000	$7,000	$7,000	$7,000	$28,000
Total Courthouse	**$42,000**	**$1,262,999**	**$42,000**	**$207,000**	**$1,553,999**
3. Jail					
Roof Replacement				$60,000	$60,000
Parking Lot Resurfacing				$50,000	$50,000
Parking Lots Sealing	$7,500	$7,500	$7,500	$7,500	$30,000
Tuckpointing	$5,000	$5,000	$5,000	$40,000	$55,000
Window Replacement	$150,000			$150,000	$300,000
Painting	$10,000	$10,000	$10,000	$10,000	$40,000
Remodeling	$50,000		$50,000		$100,000

	1 to 5 Years	6 to 10 Years	10 to 15 Years	16 to 20 Years	Total
Furnace/Air Conditioning-Repair/Rep		$150,000			$150,000
Sidewalks	$6,000				$6,000
Plumbing					$0
Electrical Upgrading	$5,000	$5,000	$5,000	$5,000	$20,000
Floor Covering	$7,500		$7,500		$15,000
Miscellaneous					$0
Total Jail	**$241,000**	**$177,500**	**$85,000**	**$322,500**	**$826,000**
4. Cooperative Extension					
Roof Replacement		$9,000			$9,000
Parking Lot Resurfacing					$0
Parking Lots Sealing	$5,000	$5,000	$5,000	$5,000	$20,000
Tuckpointing			$6,000		$6,000
Window Replacement	$8,000			$8,000	$16,000
Painting	$3,000	$3,000	$3,000	$3,000	$12,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep			$5,000		$5,000
Sidewalks					$0
Plumbing					$0
Electrical Upgrading					$0
Floor Covering		$8,000		$8,000	$16,000
Miscellaneous					$0
Total Cooperative Extension	**$16,000**	**$25,000**	**$19,000**	**$24,000**	**$84,000**
5. Friend of the Court					
Roof Replacement				$9,500	$9,500
Parking Lot Resurfacing		$25,000			$25,000
Parking Lots Sealing	$3,000	$3,000	$3,000	$3,000	$12,000
Tuckpointing					$0
Window Replacement		$10,000			$10,000
Painting	$10,000	$10,000	$10,000	$10,000	$40,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep	$8,000			$8,000	$16,000
Sidewalks	$5,000				$5,000
Plumbing					$0
Electrical Upgrading					$0
Floor Covering		$8,000		$8,000	$16,000
Miscellaneous					$0
Total Friend of the Court	**$26,000**	**$56,000**	**$13,000**	**$38,500**	**$133,500**

	1 to 5 Years	6 to 10 Years	10 to 15 Years	16 to 20 Years	Total
6. Animal Control					
Roof Replacement				$9,500	$9,500
Parking Lot Resurfacing			$15,000		$15,000
Parking Lots Sealing	$3,000	$3,000	$3,000	$3,000	$12,000
Tuckpointing	$15,000	$5,000	$5,000	$5,000	$30,000
Window Replacement	$5,000				$5,000
Painting	$6,000	$6,000	$6,000	$6,000	$24,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep		$10,000			$10,000
Sidewalks					$0
Plumbing					$0
Electrical Upgrading					$0
Floor Covering					$0
Miscellaneous					$0
Total Animal Control	**$29,000**	**$24,000**	**$29,000**	**$23,500**	**$105,500**
7. Health Department					
Roof Replacement			$50,000		$50,000
Parking Lot Resurfacing	$150,000			$150,000	$300,000
Parking Lots Sealing	$10,000	$10,000	$10,000	$10,000	$40,000
Tuckpointing	$20,000	$5,000	$5,000	$15,000	$45,000
Window Replacement			$40,000		$40,000
Painting	$20,000	$20,000	$20,000	$20,000	$80,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep			$150,000		$150,000
Sidewalks			$10,000		$10,000
Plumbing	$10,000				$10,000
Electrical Upgrading					$0
Floor Covering		$50,000		$50,000	$100,000
Miscellaneous					$0
Total Health Department	**$210,000**	**$85,000**	**$285,000**	**$245,000**	**$825,000**
8. Family Independence Agency					
Roof Replacement		$50,000			$50,000
Parking Lot Resurfacing			$50,000		$50,000
Parking Lots Sealing	$10,000	$10,000	$10,000	$10,000	$40,000
Tuckpointing	$20,000	$5,000	$5,000	$15,000	$45,000
Window Replacement			$30,000		$30,000
Painting	$5,000	$5,000	$5,000	$5,000	$20,000
Remodeling		$20,000			$20,000
Furnace/Air Conditioning-Repair/Rep			$140,000		$140,000
Sidewalks			$10,000		$10,000

	1 to 5 Years	6 to 10 Years	10 to 15 Years	16 to 20 Years	Total
Plumbing					$0
Electrical Upgrading					$0
Floor Covering		$50,000		$50,000	$100,000
Miscellaneous					$0
Total Family Independence Agency	**$35,000**	**$140,000**	**$250,000**	**$80,000**	**$505,000**
9. Dispatch					
Roof Replacement	$20,000			$20,000	$40,000
Parking Lot Resurfacing					$0
Parking Lots Sealing					$0
Tuckpointing	$10,000	$5,000	$5,000	$5,000	$25,000
Window Replacement		$10,000			$10,000
Painting	$2,500	$2,500	$2,500	$2,500	$10,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Replacement		$60,000		$60,000	$120,000
Sidewalks			$2,000		$2,000
Plumbing					$0
Electrical Upgrading					$0
Floor Covering	$4,000			$4,000	$8,000
Miscellaneous					$0
Total Dispatch	**$36,500**	**$77,500**	**$9,500**	**$91,500**	**$215,000**
10. Recycling					
Roof Replacement				$9,000	$9,000
Parking Lot Resurfacing					$0
Parking Lots Sealing					$0
Tuckpointing					$0
Window Replacement	$1,200				$1,200
Painting					$0
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep	$2,500			$2,500	$5,000
Sidewalks					$0
Plumbing					$0
Electrical Upgrading	$7,000				$7,000
Floor Covering					$0
Miscellaneous					$0
Total Recycling	**$10,700**	**$0**	**$0**	**$11,500**	**$22,200**
11. State Police					

	1 to 5 Years	6 to 10 Years	10 to 15 Years	16 to 20 Years	Total
Roof Replacement					$0
Parking Lot Resurfacing		$50,000			$50,000
Parking Lots Sealing	$10,000	$10,000	$10,000	$10,000	$40,000
Tuckpointing					$0
Window Replacement			$10,000		$10,000
Painting	$5,000	$5,000	$5,000	$5,000	$20,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Replacement		$30,000			$30,000
Sidewalks			$5,000		$5,000
Plumbing					$0
Electrical Upgrading					$0
Floor Covering	$10,000		$10,000		$20,000
Miscellaneous					$0
Total State Police	**$25,000**	**$95,000**	**$40,000**	**$15,000**	**$175,000**
12. Grant Street Pole Building					
Roof Replacement	$9,000				$9,000
Parking Lot Resurfacing					$0
Parking Lots Sealing					$0
Tuckpointing					$0
Window Replacement					$0
Painting	$2,000		$2,000		$4,000
Remodeling					$0
Furnace/Air Conditioning-Replace			$6,500		$6,500
Sidewalks					$0
Plumbing					$0
Electrical Upgrading					$0
Floor Covering					$0
Miscellaneous					$0
Total Grant Street Pole Building	**$11,000**	**$0**	**$8,500**	**$0**	**$19,500**
13. Maintance Building					
Roof Replacement				$9,000	$9,000
Parking Lot Resurfacing					$0
Parking Lots Sealing	$3,000	$3,000	$3,000	$3,000	$12,000
Tuckpointing					$0
Window Replacement			$1,200		$1,200
Painting					$0
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep			$3,000		$3,000
Sidewalks					$0
Plumbing					$0

	1 to 5 Years	6 to 10 Years	10 to 15 Years	16 to 20 Years	Total
Electrical Upgrading					$0
Floor Covering					$0
Miscellaneous					$0
Total Maintance Building	**$3,000**	**$3,000**	**$7,200**	**$12,000**	**$25,200**
14. Purdy Building					
Roof Replacement				$30,000	$30,000
Parking Lot Resurfacing					$0
Parking Lots Sealing	$1,500	$1,500	$1,500	$1,500	$6,000
Tuckpointing	$5,000	$15,000	$5,000	$5,000	$30,000
Window Replacement			$10,000		$10,000
Painting	$5,000	$5,000	$5,000	$5,000	$20,000
Remodeling					$0
Furnace/Air Conditioning-Repair/Rep			$10,000		$10,000
Sidewalks					$0
Plumbing					$0
Electrical Upgrading					$0
Floor Covering		$25,000		$25,000	$50,000
Miscellaneous					$0
Total Purdy Building	**$11,500**	**$46,500**	**$31,500**	**$66,500**	**$156,000**
12. Luder rd Pole Building					
Roof Replacement			$9,000		$9,000
Parking Lot Resurfacing					$0
Parking Lots Sealing					$0
Tuckpointing					$0
Window Replacement					$0
Painting					$0
Remodeling					$0
Furnace/Air Conditioning-Replace					$0
Sidewalks					$0
Plumbing					$0
Electrical Upgrading					$0
Floor Covering					$0
Miscellaneous					$0
Total Luder Rd Pole Building	**$0**	**$0**	**$9,000**	**$0**	**$9,000**
Total Maintenance	**$707,700**	**$2,054,499**	**$872,700**	**$1,268,000**	**$4,902,899**