(2) Funds appropriated in part 1 shall not be used by the department to adopt a rule that will apply to a small business and that will have a disproportionate economic impact on small businesses because of the size of those businesses if the department fails to reduce the disproportionate economic impact of the rule on small businesses as provided under section 40 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.240.

(3) As used in this section:

(a) "Rule" means that term as defined under section 7 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.207.

(b) "Small business" means that term as defined under section 7a of the administrative procedures act of 1969, 1969 PA 306, MCL 24.207a.

Write-offs of accounts receivable, deferrals, and prior year obligations; appropriations; limitation; report.

Sec. 216. (1) In addition to funds appropriated in part 1 for all programs and services, there is appropriated for write-offs of accounts receivable, deferrals, and for prior year obligations in excess of applicable prior year appropriations, an amount equal to total write-offs and prior year obligations, but not to exceed amounts available in prior year revenues.

(2) The department's ability to satisfy appropriation deductions in part 1 shall not be limited to collections and accruals pertaining to services provided in the current fiscal year, but shall also include reimbursements, refunds, adjustments, and settlements from prior years.

(3) The department shall report by March 15, 2008 to the house of representatives and senate appropriations subcommittees on community health on all reimbursements, refunds, adjustments, and settlements from prior years.

Basic health services.

Sec. 218. Basic health services for the purpose of part 23 of the public health code, 1978 PA 368, MCL 333.2301 to 333.2321, are: immunizations, communicable disease control, sexually transmitted disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, screening newborns for the 8 conditions listed in section 5431(1)(a) through (h) of the public health code, 1978 PA 368, MCL 333.5431, community health annex of the Michigan emergency management plan, and prenatal care.

Michigan public health institute; design and implementation of projects; copy of reports, studies, and publications.

Sec. 219. (1) The department may contract with the Michigan public health institute for the design and implementation of projects and for other public health related activities prescribed in section 2611 of the public health code, 1978 PA 368, MCL 333.2611. The department may develop a master agreement with the institute to carry out these purposes for up to a 3-year period. The department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on or before November 1, 2007 and May 1, 2008 all of the following:

(a) A detailed description of each funded project.

(b) The amount allocated for each project, the appropriation line item from which the allocation is funded, and the source of financing for each project.

(c) The expected project duration.

(d) A detailed spending plan for each project, including a list of all subgrantees and the amount allocated to each subgrantee.

(2) On or before September 30, 2008, the department shall provide to the same parties listed in subsection (1) a copy of all reports, studies, and publications produced by the Michigan public health institute, its subcontractors, or the department with the funds appropriated in part 1 and allocated to the Michigan public health institute.

Michigan public health institute; submission to financial and performance audits.

Sec. 220. All contracts with the Michigan public health institute funded with appropriations in part 1 shall include a requirement that the Michigan public health institute submit to financial and performance audits by the state auditor general of projects funded with state appropriations.

Fees for publications, videos and related materials, conferences, and workshops; establishment and collection.

Sec. 223. The department of community health may establish and collect fees for publications, videos and related materials, conferences, and workshops. Collected fees shall be used to offset expenditures to pay for printing and mailing costs of the publications, videos and related materials, and costs of the workshops and conferences. The costs shall not exceed fees collected.

Participation of ambulatory surgery centers in Medicaid program.

Sec. 248. The department shall allow ambulatory surgery centers in this state to fully participate in the Medicaid program when hospitals are reimbursed for Medicaid services through the new Michigan Medicaid information system. Ambulatory surgery centers that provide services to Medicaid-eligible patients shall be reimbursed in the same manner as hospitals. The reimbursement schedule for ambulatory surgery centers shall be developed and implemented in consultation with the industry and shall be provided to the senate and house appropriations subcommittees on the department of community health and the senate and house fiscal agencies by July 1, 2008.

Technology-related services and projects; payment of user fees.

Sec. 259. From the funds appropriated in part 1 for information technology, the department shall pay user fees to the department of information technology for technology-related services and projects. Such user fees shall be subject to provisions of an interagency agreement between the department and the department of information technology.

Information technology; designation of amounts as work projects.

Sec. 260. Amounts appropriated in part 1 for information technology may be designated as work projects and carried forward to support technology projects under the direction of the department of information technology. Funds designated in this manner are not available for expenditure until approved as work projects under section 451a of the management and budget act, 1984 PA 431, MCL 18.1451a.

Medicaid management information system upgrade; contingency on approval of advanced planning document.

Sec. 261. Funds appropriated in part 1 for the Medicaid management information system upgrade are contingent upon approval of an advanced planning document from the centers for Medicare and Medicaid services. If the necessary matching funds are identified and legislatively transferred to this line item, the corresponding federal Medicaid revenue shall be appropriated at a 90/10 federal/state match rate. This appropriation may be designated as a work project and carried forward to support completion of this project.

Medicaid waiver applications; notification; reports.

Sec. 264. (1) Upon submission of a Medicaid waiver, a Medicaid state plan amendment, or a similar proposal to the centers for Medicare and Medicaid services, the department shall notify the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies of the submission.

(2) The department shall provide written or verbal quarterly reports to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies summarizing the status of any new or ongoing discussions with the centers for Medicare and Medicaid services or the federal department of health and human services regarding potential or future Medicaid waiver applications.

Receipt and retention of reports.

Sec. 265. The departments and agencies receiving appropriations in part 1 shall receive and retain copies of all reports funded from appropriations in part 1. Federal and state guidelines for short-term and long-term retention of records shall be followed.

Out-of-state travel; exceptions; report.

Sec. 266. (1) Due to the current budgetary problems in this state, out-of-state travel shall be limited to situations in which 1 or more of the following conditions apply:

(a) The travel is required by legal mandate or court order or for law enforcement purposes.

(b) The travel is necessary to protect the health or safety of Michigan citizens or visitors or to assist other states in similar circumstances.

(c) The travel is necessary to produce budgetary savings or to increase state revenues, including protecting existing federal funds or securing additional federal funds.

(d) The travel is necessary to comply with federal requirements.

(e) The travel is necessary to secure specialized training for staff that is not available within this state.

(f) The travel is financed entirely by federal or nonstate funds.

(2) If out-of-state travel is necessary but does not meet 1 or more of the conditions in subsection (1), the state budget director may grant an exception to allow the travel. Any exceptions granted by the state budget director shall be reported on a monthly basis to the house of representatives and senate standing committees on appropriations.

(3) Not later than January 1 of each year, each department shall prepare a travel report listing all travel by classified and unclassified employees outside this state in the immediately preceding fiscal year that was funded in whole or in part with funds appropriated in the department's budget. The report shall be submitted to the chairs and members of the house of representatives and senate standing committees on appropriations, the fiscal agencies, and the state budget director. The report shall include the following information:

(a) The name of each person receiving reimbursement for travel outside this state or whose travel costs were paid by this state.

(b) The destination of each travel occurrence.

(c) The dates of each travel occurrence.

(d) A brief statement of the reason for each travel occurrence.

(e) The transportation and related costs of each travel occurrence, including the proportion funded with state general fund/general purpose revenues, the proportion funded with state-restricted revenues, the proportion funded with federal revenues, and the proportion funded with other revenues.

(f) A total of all out-of-state travel funded for the immediately preceding fiscal year.

Communication of employee with legislative member or staff.

Sec. 267. A department or state agency shall not take disciplinary action against an employee for communicating with a member of the legislature or his or her staff.

Reimbursement of mental health medications.

Sec. 269. The amount appropriated in part 1 for medical services pharmaceutical services includes funds to cover reimbursement of mental health medications under the Medicaid program. Reimbursement procedures for mental health medications shall be the same as those that were followed in fiscal year 2005-2006, and utilization procedures for such medications shall adhere to section 1625, the department's fiscal year 2006-2007 contract with Medicaid health plans, and section 109h of the social welfare act, 1939 PA 280, MCL 400.109h.

Legal action to recover expenses; notification from attorney general's office; report.

Sec. 270. Within 30 days after receipt of the notification from the attorney general's office of a legal action in which expenses had been recovered pursuant to section 106(4) of the social welfare act, 1939 PA 280, MCL 400.106, or any other statute under which the department has the right to recover expenses, the department shall submit a written report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office which includes, at a minimum, all of the following:

(a) The total amount recovered from the legal action.

(b) The program or service for which the money was originally expended.

(c) Details on the disposition of the funds recovered such as the appropriation or revenue account in which the money was deposited.

(d) A description of the facts involved in the legal action.

Early mental health services intervention pilot project; determination of cost effectiveness; request for Medicaid state plan amendments or waivers; progress report.

Sec. 271. (1) A PIHP, Medicaid HMO, and federally qualified health center may establish and implement an early mental health services intervention pilot project. This project shall provide care coordination, disease management, and pharmacy management to eligible recipients suffering from chronic disease, including, but not limited to, diabetes, asthma, substance addiction, or stroke. Participating organizations may make use of data sharing, joint information technology efforts, and financial incentives to health providers and recipients in this project.

(2) The pilot project shall make use of preestablished objectives and outcome measures to determine the cost effectiveness of the project. Data shall also be collected by participating organizations to study and monitor the correlation between early mental health treatment services to program participants and improvement in the management of their chronic disease.

(3) The department shall request any necessary Medicaid state plan amendments or waivers to ensure participation in this project by eligible Medicaid recipients.

(4) A progress report on the pilot project shall be provided to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director no later than May 1, 2008.

Administrative efficiencies; study of current policies and allocation methodologies; range of options; consultation with applicable organizations; expenditures; submission of results.

Sec. 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.

Legal services.

Sec. 276. Funds appropriated in part 1 shall not be used by a principal executive department, state agency, or authority to hire a person to provide legal services that are the responsibility of the attorney general. This prohibition does not apply to legal services for bonding activities and for those activities that the attorney general authorizes.

Administrative costs; establishment of definitions, standards, and instructions; written draft.

Sec. 282. (1) The department, through its organizational units responsible for departmental administration, operation, and finance, shall establish uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by the following entities:

(a) Coordinating agencies on substance abuse, Salvation Army harbor light program, and their subcontractors that receive payment or reimbursement from funds appropriated under section 104 of part 1.

(b) Area agencies on aging and local providers, and their subcontractors that receive payment or reimbursement from funds appropriated under section 118 of part 1.

(2) By May 15, 2008, the department shall provide a written draft of its proposed definitions, standards, and instructions to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

DEPARTMENTWIDE ADMINISTRATION

Employees returning to work under limited duty assignments; payments in lieu of worker's compensation.

Sec. 301. From funds appropriated for worker's compensation, the department may make payments in lieu of worker's compensation payments for wage and salary and related fringe benefits for employees who return to work under limited duty assignments.

First-party payment; mental health services; prohibition.

Sec. 303. The department is prohibited from requiring first-party payment from individuals or families with a taxable income of $10,000.00 or less for mental health services for determinations made in accordance with section 818 of the mental health code, 1974 PA 258, MCL 330.1818.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Protection and advocacy service; contract; purposes.

Sec. 350. The department may enter into a contract with the protection and advocacy service, authorized under section 931 of the mental health code, 1974 PA 258, MCL 330.1931, or a similar organization to provide legal services for purposes of gaining and maintaining occupancy in a community living arrangement which is under lease or contract with the department or a community mental health services program to provide services to persons with mental illness or developmental disability.

Methamphetamine cleanup efforts.

Sec. 351. (1) From the funds appropriated in part 1 for the methamphetamine cleanup fund, the department shall allow local governments to apply for money to cover their administrative costs associated with the methamphetamine cleanup efforts. The funds allocated to local governments for the administrative costs associated with methamphetamine cleanup efforts shall not exceed $800.00 per property.

(2) The department shall work with the Michigan association of counties to ensure that counties are aware that the funds appropriated in part 1 for methamphetamine cleanup activities are available.

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

CMHSP or PIHP; services to be provided.

Sec. 401. Funds appropriated in part 1 are intended to support a system of comprehensive community mental health services under the full authority and responsibility of local CMHSPs or PIHPs. The department shall ensure that each CMHSP or PIHP provides all of the following:

(a) A system of single entry and single exit.

(b) A complete array of mental health services which shall include, but shall not be limited to, all of the following services: residential and other individualized living arrangements, outpatient services, acute inpatient services, and long-term, 24-hour inpatient care in a structured, secure environment.

(c) The coordination of inpatient and outpatient hospital services through agreements with state-operated psychiatric hospitals, units, and centers in facilities owned or leased by the state, and privately-owned hospitals, units, and centers licensed by the state pursuant to sections 134 through 149b of the mental health code, 1974 PA 258, MCL 330.1134 to 330.1149b.

(d) Individualized plans of service that are sufficient to meet the needs of individuals, including those discharged from psychiatric hospitals or centers, and that ensure the full range of recipient needs is addressed through the CMHSP's or PIHP's program or through assistance with locating and obtaining services to meet these needs.

(e) A system of case management or care management to monitor and ensure the provision of services consistent with the individualized plan of services or supports.

(f) A system of continuous quality improvement.

(g) A system to monitor and evaluate the mental health services provided.

(h) A system that serves at-risk and delinquent youth as required under the provisions of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

Authorizations to CMHSPs or PIHPs; contracts; report.

Sec. 402. (1) From funds appropriated in part 1, final authorizations to CMHSPs or PIHPs shall be made upon the execution of contracts between the department and CMHSPs or PIHPs. The contracts shall contain an approved plan and budget as well as policies and procedures governing the obligations and responsibilities of both parties to the contracts. Each contract with a CMHSP or PIHP that the department is authorized to enter into under this subsection shall include a provision that the contract is not valid unless the total dollar obligation for all of the contracts between the department and the CMHSPs or PIHPs entered into under this subsection for fiscal year 2007-2008 does not exceed the amount of money appropriated in part 1 for the contracts authorized under this subsection.

(2) The department shall immediately report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director if either of the following occurs:

(a) Any new contracts with CMHSPs or PIHPs that would affect rates or expenditures are enacted.

(b) Any amendments to contracts with CMHSPs or PIHPs that would affect rates or expenditures are enacted.

(3) The report required by subsection (2) shall include information about the changes and their effects on rates and expenditures.

Multicultural services.

Sec. 403. (1) From the funds appropriated in part 1 for multicultural services, the department shall ensure that CMHSPs or PIHPs meet with multicultural service providers to develop a workable framework for contracting, service delivery, and reimbursement.

(2) Funds appropriated in part 1 for multicultural services shall not be utilized for services provided to illegal immigrants. The department shall modify contracts with recipients of multicultural services grants to mandate that grantees establish that recipients of services are legally residing in the United States. An exception to the contractual provision will be allowed to address persons presenting with emergent mental health conditions.

Community mental health services programs; report; inclusion of data reporting requirements.

Sec. 404. (1) Not later than May 31 of each fiscal year, the department shall provide a report on the community mental health services programs to the members of the house of

representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director that includes the information required by this section.

(2) The report shall contain information for each CMHSP or PIHP and a statewide summary, each of which shall include at least the following information:

(a) A demographic description of service recipients which, minimally, shall include reimbursement eligibility, client population, age, ethnicity, housing arrangements, and diagnosis.

(b) Per capita expenditures by client population group.

(c) Financial information which, minimally, shall include a description of funding authorized; expenditures by client group and fund source; and cost information by service category, including administration. Service category shall include all department-approved services.

(d) Data describing service outcomes which shall include, but not be limited to, an evaluation of consumer satisfaction, consumer choice, and quality of life concerns including, but not limited to, housing and employment.

(e) Information about access to community mental health services programs which shall include, but not be limited to, the following:

(*i*) The number of people receiving requested services.

(*ii*) The number of people who requested services but did not receive services.

(f) The number of second opinions requested under the code and the determination of any appeals.

(g) An analysis of information provided by community mental health services programs in response to the needs assessment requirements of the mental health code, including information about the number of persons in the service delivery system who have requested and are clinically appropriate for different services.

(h) Lapses and carryforwards during fiscal year 2006-2007 for CMHSPs or PIHPs.

(i) Information about contracts for mental health services entered into by CMHSPs or PIHPs with providers, including, but not limited to, all of the following:

(*i*) The amount of the contract, organized by type of service provided.

(*ii*) Payment rates, organized by the type of service provided.

(*iii*) Administrative costs for services provided to CMHSPs or PIHPs.

(j) Information on the community mental health Medicaid managed care program, including, but not limited to, both of the following:

(*i*) Expenditures by each CMHSP or PIHP organized by Medicaid eligibility group, including per eligible individual expenditure averages.

(*ii*) Performance indicator information required to be submitted to the department in the contracts with CMHSPs or PIHPs.

(k) An estimate of the number of direct care workers in local residential settings and paraprofessional and other nonprofessional direct care workers in settings where skill building, community living supports and training, and personal care services are provided by CMHSPs or PIHPs as of September 30, 2007 employed directly or through contracts with provider organizations.

(3) The department shall include data reporting requirements listed in subsection (2) in the annual contract with each individual CMHSP or PIHP.

(4) The department shall take all reasonable actions to ensure that the data required are complete and consistent among all CMHSPs or PIHPs.

Direct care workers; employee wage pass-through; report.

Sec. 405. (1) It is the intent of the legislature that the employee wage pass-through funded in previous years, including the 2% wage increase funded in fiscal year 2006-2007, to the community mental health services programs for direct care workers in local residential settings and for paraprofessional and other nonprofessional direct care workers in settings where skill building, community living supports and training, and personal care services are provided shall continue to be paid to direct care workers.

(2) Each CMHSP or PIHP awarded wage pass-through funds in fiscal year 2006-2007 shall report on the actual expenditures of such funds in the format to be determined by the department.

Substance abuse residential facilities; room and board payments; eligibility of clients; reimbursement rates.

Sec. 406. (1) The funds appropriated in part 1 for the state disability assistance substance abuse services program shall be used to support per diem room and board payments in substance abuse residential facilities. Eligibility of clients for the state disability assistance substance abuse services program shall include needy persons 18 years of age or older, or emancipated minors, who reside in a substance abuse treatment center.

(2) The department shall reimburse all licensed substance abuse programs eligible to participate in the program at a rate equivalent to that paid by the department of human services to adult foster care providers. Programs accredited by department-approved accrediting organizations shall be reimbursed at the personal care rate, while all other eligible programs shall be reimbursed at the domiciliary care rate.

Substance abuse prevention, education, and treatment grants; contracts with coordinating agencies; fee schedule.

Sec. 407. (1) The amount appropriated in part 1 for substance abuse prevention, education, and treatment grants shall be expended for contracting with coordinating agencies. Coordinating agencies shall work with the CMHSPs or PIHPs to coordinate the care and services provided to individuals with both mental illness and substance abuse diagnoses.

(2) The department shall approve a fee schedule for providing substance abuse services and charge participants in accordance with their ability to pay.

Substance abuse prevention, education, and treatment programs; data to be reported.

Sec. 408. (1) By April 15, 2008, the department shall report the following data from fiscal year 2006-2007 on substance abuse prevention, education, and treatment programs to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget office:

(a) Expenditures stratified by coordinating agency, by central diagnosis and referral agency, by fund source, by subcontractor, by population served, and by service type. Additionally, data on administrative expenditures by coordinating agency and by subcontractor shall be reported.

(b) Expenditures per state client, with data on the distribution of expenditures reported using a histogram approach.

(c) Number of services provided by central diagnosis and referral agency, by subcontractor, and by service type. Additionally, data on length of stay, referral source, and participation in other state programs.

(d) Collections from other first- or third-party payers, private donations, or other state or local programs, by coordinating agency, by subcontractor, by population served, and by service type.

(2) The department shall take all reasonable actions to ensure that the required data reported are complete and consistent among all coordinating agencies.

Substance abuse services; distribution of funds; priority to providers furnishing child care services.

Sec. 409. The funding in part 1 for substance abuse services shall be distributed in a manner that provides priority to service providers that furnish child care services to clients with children.

Substance abuse treatment to applicants and recipients of public assistance; condition of eligibility.

Sec. 410. The department shall assure that substance abuse treatment is provided to applicants and recipients of public assistance through the department of human services who are required to obtain substance abuse treatment as a condition of eligibility for public assistance.

Diversion from jail incarceration.

Sec. 411. (1) The department shall ensure that each contract with a CMHSP or PIHP requires the CMHSP or PIHP to implement programs to encourage diversion of persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.

(2) Each CMHSP or PIHP shall have jail diversion services and shall work toward establishing working relationships with representative staff of local law enforcement agencies, including county prosecutors' offices, county sheriffs' offices, county jails, municipal police agencies, municipal detention facilities, and the courts. Written interagency agreements describing what services each participating agency is prepared to commit to the local jail diversion effort and the procedures to be used by local law enforcement agencies to access mental health jail diversion services are strongly encouraged.

Salvation Army harbor light program; contract to provide non-Medicaid substance abuse services.

Sec. 412. The department shall contract directly with the Salvation Army harbor light program to provide non-Medicaid substance abuse services at not less than the amount contracted for in fiscal year 2006-2007.

Specialized substance abuse services; management by selected PIHPs.

Sec. 414. Medicaid substance abuse treatment services shall be managed by selected PIHPs pursuant to the centers for Medicare and Medicaid services' approval of Michigan's 1915(b) waiver request to implement a managed care plan for specialized substance abuse services. The selected PIHPs shall receive a capitated payment on a per eligible per month basis to assure provision of medically necessary substance abuse services to all beneficiaries who require those services. The selected PIHPs shall be responsible for the reimbursement of claims for specialized substance abuse services. The PIHPs that are not coordinating agencies may continue to contract with a coordinating agency. Any alternative arrangement must be based on client service needs and have prior approval from the department.

Medicaid managed mental health care program; amount of funding to PIHPs; report.

Sec. 418. On or before the tenth of each month, the department shall report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the amount of funding paid to PIHPs to support the Medicaid managed mental health care program in that month.

The information shall include the total paid to each PIHP, per capita rate paid for each eligibility group for each PIHP, and number of cases in each eligibility group for each PIHP, and year-to-date summary of eligibles and expenditures for the Medicaid managed mental health care program.

Delivery of substance abuse prevention, education, and treatment programs; work with other departments; work group.

Sec. 423. (1) The department shall work cooperatively with the departments of human services, corrections, education, state police, and military and veterans affairs to coordinate and improve the delivery of substance abuse prevention, education, and treatment programs within existing appropriations.

(2) The department shall establish a work group composed of representatives of the department, the departments of human services, corrections, education, state police, and military and veterans affairs, coordinating agencies, CMHSPs, and any other persons considered appropriate to examine and review the source and expenditure of all public and private funds made available for substance abuse programs and services. The work group shall develop and recommend cost-effective measures for the expenditure of funds and delivery of substance abuse programs and services. The department shall submit the findings of the work group to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by May 31, 2008.

Claims processing and payment procedure.

Sec. 424. Each PIHP that contracts with the department to provide services to the Medicaid population shall adhere to the following timely claims processing and payment procedure for claims submitted by health professionals and facilities:

(a) A "clean claim" as described in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i, must be paid within 45 days after receipt of the claim by the PIHP. A clean claim that is not paid within this time frame shall bear simple interest at a rate of 12% per annum.

(b) A PIHP must state in writing to the health professional or facility any defect in the claim within 30 days after receipt of the claim.

(c) A health professional and a health facility have 30 days after receipt of a notice that a claim or a portion of a claim is defective within which to correct the defect. The PIHP shall pay the claim within 30 days after the defect is corrected.

Consultation to department of corrections.

Sec. 425. If House Bill No. 4348 of the 94th Legislature is enacted into law, the department shall provide the consultation to the department of corrections in completing the independent study required in section 302 of that bill.

Increase of capitation rates for PIHPs; state match funds.

Sec. 428. Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

Matching funds to CMHSP for mental health services; installments.

Sec. 435. A county required under the provisions of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106, to provide matching funds to a CMHSP for mental health services rendered to residents in its jurisdiction shall pay the matching funds in equal installments

on not less than a quarterly basis throughout the fiscal year, with the first payment being made by October 1, 2007.

Medicaid adult benefits waiver program.

Sec. 442. (1) It is the intent of the legislature that the $40,000,000.00 in funding transferred from the community mental health non-Medicaid services line to support the Medicaid adult benefits waiver program be used to provide state match for increases in federal funding for primary care and specialty services provided to Medicaid adult benefits waiver enrollees and for economic increases for the Medicaid specialty services and supports program.

(2) The department shall assure that persons enrolled in the Medicaid adult benefits waiver program shall receive mental health services as approved in the state plan amendment.

(3) Capitation payments to CMHSPs for persons who become enrolled in the Medicaid adult benefits waiver program shall be made using the same rate methodology as payments for the current Medicaid beneficiaries.

(4) If enrollment in the Medicaid adult benefits waiver program does not achieve expectations and the funding appropriated for the Medicaid adult benefits waiver program for specialty services is not expended, the general fund balance shall be transferred back to the community mental health non-Medicaid services line. The department shall report quarterly to the senate and house of representatives appropriations subcommittees on community health a summary of eligible expenditures for the Medicaid adult benefits waiver program by CMHSPs.

Implementation of retroactive policy leading to negative financial impact; prohibition.

Sec. 452. Unless otherwise authorized by law, the department shall not implement retroactively any policy that would lead to a negative financial impact on community mental health services programs or prepaid inpatient health plans.

Individuals with mental illness, developmental disabilities, or substance abuse issues; consumer choice.

Sec. 456. (1) CMHSPs and PIHPs shall honor consumer choice to the fullest extent possible when providing services and support programs for individuals with mental illness, developmental disabilities, or substance abuse issues. Consumer choices shall include skill-building assistance, rehabilitative and habilitative services, supported and integrated employment services program settings, and other work preparatory services provided in the community or by accredited community-based rehabilitation organizations. CMHSPs and PIHPs shall not arbitrarily eliminate or restrict any choices from the array of services and program settings available to consumers without reasonable justification that those services are not in the consumer's best interest.

(2) CMHSPs and PIHPs shall take all necessary steps to ensure that individuals with mental illness, developmental disabilities, or substance abuse issues be placed in the least restrictive setting in the quickest amount of time possible if it is the individual's choice.

Plan and report to be provided to legislature and state budget director.

Sec. 458. By April 15, 2008, the department shall provide each of the following to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director:

(a) An updated plan for implementing recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004.

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. This report shall examine the potential impact that utilization of secure residential facilities would have upon the state's need for adult mental health facilities.

(c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

Reporting of administrative costs by PIHPs, CMHSPs, and contracted organized provider systems.

Sec. 460. (1) The uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by PIHPs, CMHSPs, and contracted organized provider systems that receive payment or reimbursement from funds appropriated under section 104 of part 1 that were implemented in fiscal year 2006-2007 by the department shall also be implemented for their subcontractors in fiscal year 2007-2008.

(2) The department shall provide the house of representatives and senate appropriations subcommittees on community health, the house of representatives and senate fiscal agencies, and the state budget director with a progress report on the implementation required under subsection (1). The progress report is due on July 1, 2008.

Equity funding plan.

Sec. 462. The department shall implement a funding equity plan for all CMHSPs that receive funds appropriated under the community mental health non-Medicaid services line. The funding plan should reflect a combination of a more equitable distribution methodology based on proxy measures of need and the recognition of varying expenditure needs of CMHSPs. The department shall submit the written equity funding plan to the senate and house subcommittees on community health, the senate and house fiscal agencies, and the state budget director by March 1, 2008.

Reduction and prevention of incidence of substance abuse; assessment of program effectiveness.

Sec. 463. The department shall use standard program evaluation measures to assess the overall effectiveness of programs provided through coordinating agencies and service providers in reducing and preventing the incidence of substance abuse. The measures established by the department shall be modeled after the program outcome measures and best practice guidelines for the treatment of substance abuse as proposed by the federal substance abuse and mental health services administration.

Prevention, rehabilitation, care, and treatment of alcoholics; use of revenue from liquor license fees.

Sec. 464. It is the intent of the legislature that revenue received by the department from liquor license fees be expended at not less than the amount provided in fiscal year 2006-2007, to fund programs for the prevention, rehabilitation, care, and treatment of alcoholics pursuant to sections 543(1) and 1115(2) of the Michigan liquor control code of 1998, 1998 PA 58, MCL 436.1543 and 436.2115.

Respite care services for children.

Sec. 465. Funds appropriated in part 1 for respite services shall be used for direct respite care services for children with serious emotional disturbances and their families. Not more

than 1% of the funds allocated for respite services shall be expended by CMHSPs for administration and administrative purposes.

Funding to substance abuse coordinating agencies; increased funding; condition.

Sec. 467. If funds become available, the department shall increase funding paid from the community substance abuse prevention, education, and treatment programs line item to the substance abuse coordinating agencies to the level of funding provided in fiscal year 2002-2003.

Incorporation of city, county, or regional substance abuse coordinating agency into local community mental health authority; changes to criteria.

Sec. 468. To foster a more efficient administration of and to integrate care in publicly funded mental health and substance abuse services, the department shall recommend changes in its criteria for the incorporation of a city, county, or regional substance abuse coordinating agency into a local community mental health authority that will encourage those city, county, or regional coordinating agencies to incorporate as local community mental health authorities. If necessary, the department may make accommodations or adjustments in formula distribution to address administrative costs related to the recommended changes to the criteria made in accordance with this section and to the incorporation of the additional coordinating agencies into local community mental health authorities provided that all of the following are satisfied:

(a) The department provides funding for the administrative costs incurred by coordinating agencies incorporating into community mental health authorities. The department shall not provide more than $75,000.00 to any coordinating agency for administrative costs.

(b) The accommodations or adjustments do not favor coordinating agencies who voluntarily elect to integrate with local community mental health authorities.

(c) The accommodations or adjustments do not negatively affect other coordinating agencies.

Substance abuse coordinating agencies incorporated into community mental health authorities; accepting funding for administrative costs; written expectations; report.

Sec. 470. (1) For those substance abuse coordinating agencies that have voluntarily incorporated into community mental health authorities and accepted funding from the department for administrative costs incurred pursuant to section 468 of this act, the department shall establish written expectations for those CMHSPs, PIHPs, and substance abuse coordinating agencies and counties with respect to the integration of mental health and substance abuse services. At a minimum, the written expectations shall provide for the integration of those services as follows:

(a) Coordination and consolidation of administrative functions and redirection of efficiencies into service enhancements.

(b) Consolidation of points of 24-hour access for mental health and substance abuse services in every community.

(c) Alignment of coordinating agencies and PIHPs boundaries to maximize opportunities for collaboration and integration of administrative functions and clinical activities.

(2) By May 1, 2008, the department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office on the impact and effectiveness of this section and the status of the integration of mental health and substance abuse services.

Guardianship and alternatives to guardianship.

Sec. 474. The department shall ensure that each contract with a CMHSP or PIHP requires the CMHSP or PIHP to provide each recipient and his or her family with information regarding the different types of guardianship and the alternatives to guardianship. A CMHSP or PIHP shall not, in any manner, attempt to reduce or restrict the ability of a recipient or his or her family from seeking to obtain any form of legal guardianship without just cause.

Regional jail diversion pilot program.

Sec. 476. From the funds appropriated in part 1 for community mental health non-Medicaid services, $100.00 shall be used to fund a regional jail diversion pilot program that is located in a county with a population of more than 1,000,000 but not more than 1,750,000. The regional jail diversion pilot program shall incorporate a system for the identification and diversion of mentally ill and dually-diagnosed individuals from the criminal justice system before the individual's contact with a law enforcement officer results in the individual being detained in a jail or holding cell. The regional jail diversion pilot program shall divert those individuals to a secure environment where those individuals can be stabilized, evaluated, and receive the appropriate mental health treatment.

Recovery coaching pilot program.

Sec. 477. From the funds appropriated in part 1 for community substance abuse prevention, education, and treatment programs, $100.00 shall be used to establish a recovery coaching pilot program to assist individuals who are current or former substance abusers to achieve rehabilitation and long-term recovery.

Atypical antipsychotic prescriptions; report on number and reimbursement cost.

Sec. 480. The department shall provide to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by March 30, 2008 a report on the number and reimbursement cost of atypical antipsychotic prescriptions by each PIHP for Medicaid beneficiaries.

STATE PSYCHIATRIC HOSPITALS, CENTERS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AND FORENSIC AND PRISON MENTAL HEALTH SERVICES

Third-party payments for services; collection; revenue recapture project.

Sec. 601. (1) In funding of staff in the financial support division, reimbursement, and billing and collection sections, priority shall be given to obtaining third-party payments for services. Collection from individual recipients of services and their families shall be handled in a sensitive and nonharassing manner.

(2) The department shall continue a revenue recapture project to generate additional revenues from third parties related to cases that have been closed or are inactive. Revenues collected through project efforts are appropriated to the department for departmental costs and contractual fees associated with these retroactive collections and to improve ongoing departmental reimbursement management functions.

Patient living and treatment environments; carrying forward unexpended and unencumbered amounts; use of gifts and bequests.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $1,000,000.00 remaining on September 30, 2008 from the amounts appropriated in part 1 for gifts and bequests for patient living and treatment environments shall be carried forward for 1 fiscal year. The purpose of gifts and bequests for patient living and treatment environments is to use additional private funds to provide specific enhancements for individuals residing at state-operated facilities. Use of the gifts and bequests shall be consistent with the stipulation of the donor. The expected completion date for the use of gifts and bequests donations is within 3 years unless otherwise stipulated by the donor.

Forensic mental health services provided to department of corrections.

Sec. 603. The funds appropriated in part 1 for forensic mental health services provided to the department of corrections are in accordance with the interdepartmental plan developed in cooperation with the department of corrections. The department is authorized to receive and expend funds from the department of corrections in addition to the appropriations in part 1 to fulfill the obligations outlined in the interdepartmental agreements.

Annual reports provided by CMHSPs or PIHPs; information.

Sec. 604. (1) The CMHSPs or PIHPs shall provide annual reports to the department on the following information:

(a) The number of days of care purchased from state hospitals and centers.

(b) The number of days of care purchased from private hospitals in lieu of purchasing days of care from state hospitals and centers.

(c) The number and type of alternative placements to state hospitals and centers other than private hospitals.

(d) Waiting lists for placements in state hospitals and centers.

(2) The department shall annually report the information in subsection (1) to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

Closures or consolidations of state hospitals, centers, or agencies; conditions.

Sec. 605. (1) The department shall not implement any closures or consolidations of state hospitals, centers, or agencies until CMHSPs or PIHPs have programs and services in place for those persons currently in those facilities and a plan for service provision for those persons who would have been admitted to those facilities.

(2) All closures or consolidations are dependent upon adequate department-approved CMHSP and PIHP plans that include a discharge and aftercare plan for each person currently in the facility. A discharge and aftercare plan shall address the person's housing needs. A homeless shelter or similar temporary shelter arrangements are inadequate to meet the person's housing needs.

(3) Four months after the certification of closure required in section 19(6) of the state employees' retirement act, 1943 PA 240, MCL 38.19, the department shall provide a closure plan to the house of representatives and senate appropriations subcommittees on community health and the state budget director.

(4) Upon the closure of state-run operations and after transitional costs have been paid, the remaining balances of funds appropriated for that operation shall be transferred to CMHSPs or PIHPs responsible for providing services for persons previously served by the operations.

Patient reimbursement from first- and third-party payers; collection of revenue.

Sec. 606. The department may collect revenue for patient reimbursement from first- and third-party payers, including Medicaid and local county CMHSP payers, to cover the cost of placement in state hospitals and centers. The department is authorized to adjust financing sources for patient reimbursement based on actual revenues earned. If the revenue collected exceeds current year expenditures, the revenue may be carried forward with approval of the state budget director. The revenue carried forward shall be used as a first source of funds in the subsequent year.

Mandated changes in operation of state hospitals and centers; support.

Sec. 607. If Senate Bill No. 369 of the 94th Legislature is enacted into law, the department shall provide all necessary support to state hospitals to ensure that mandated changes in the operation of state hospitals and centers are completed in a timely and efficient manner.

Privatization of food and custodial services; evaluation.

Sec. 608. By May 1, 2008, the department shall evaluate the privatization of food and custodial services at all of the state hospitals and centers and submit a copy of the evaluation to the house and senate appropriations subcommittees on community health and to the house and senate fiscal agencies. The evaluation shall include a detailed cost-benefit analysis utilizing accurate, reliable, and objective data that compares state costs versus the contractual costs over the life of a contract. If the evaluation identifies privatization savings of at least 10%, the department, in consultation with the department of management and budget, shall establish and implement a bid process to identify 1 or more private or public contractors to provide food service and custodial services at each state hospital and center.

PUBLIC HEALTH ADMINISTRATION

Annual public health consumption advisory for sportfish.

Sec. 650. The department shall communicate the annual public health consumption advisory for sportfish. The department shall, at a minimum, post the advisory on the Internet and make the information in the advisory available to the clients of the women, infants, and children special supplemental nutrition program.

"Healthy Michigan 2010" report; improvement of health status of citizens.

Sec. 651. By April 30, 2008, the department shall submit a report to the house and senate fiscal agencies and the state budget director on the activities and efforts of the department to improve the health status of the citizens of this state with regard to the goals and objectives stated in the "Healthy Michigan 2010" report, and the measurable progress made toward those goals and objectives.

HEALTH POLICY, REGULATION, AND PROFESSIONS

Qualified emergency medical services personnel; sufficient number to serve rural areas.

Sec. 704. The department shall continue to contract with grantees supported through the appropriation in part 1 for the emergency medical services grants and contracts to ensure

that a sufficient number of qualified emergency medical services personnel exist to serve rural areas of the state.

Inspection summary of licensed nursing home; posting on Internet.

Sec. 705. The department shall post on the Internet the executive summary of the latest inspection for each licensed nursing home.

Nursing home inspectors; hiring experienced individuals.

Sec. 706. When hiring any new nursing home inspectors funded through appropriations in part 1, the department shall make every effort to hire individuals with past experience in the long-term care industry.

Nursing scholarship program; use of funds to increase number of nurses.

Sec. 707. The funds appropriated in part 1 for the nursing scholarship program, established in section 16315 of the public health code, 1978 PA 368, MCL 333.16315, shall be used to increase the number of nurses practicing in Michigan. The board of nursing is encouraged to structure scholarships funded under this act in a manner that rewards recipients who intend to practice nursing in Michigan. In addition, the department and the board of nursing shall work cooperatively with the Michigan higher education assistance authority to coordinate scholarship assistance with scholarships provided pursuant to the Michigan nursing scholarship act, 2002 PA 591, MCL 390.1181 to 390.1189.

Total monthly patient care hours and percentage of pool staff used; report.

Sec. 708. Nursing facilities shall report in the quarterly staff report to the department, the total patient care hours provided each month, by state licensure and certification classification, and the percentage of pool staff, by state licensure and certification classification, used each month during the preceding quarter. The department shall make available to the public, the quarterly staff report compiled for all facilities including the total patient care hours and the percentage of pool staff used, by classification.

Loan repayment for dentists.

Sec. 709. The funds appropriated in part 1 for the Michigan essential health care provider program may also provide loan repayment for dentists that fit the criteria established by part 27 of the public health code, 1978 PA 368, MCL 333.2701 to 333.2727.

Federally qualified health centers; enhancement of service capacity.

Sec. 710. From the funds appropriated in part 1 for primary care services, an amount not to exceed $2,172,700.00 is appropriated to enhance the service capacity of the federally qualified health centers and other health centers which are similar to federally qualified health centers.

Nonconfidential information; availability of customized listings; revenue.

Sec. 711. The department may make available to interested entities customized listings of nonconfidential information in its possession, such as names and addresses of licensees. The department may establish and collect a reasonable charge to provide this service. The revenue received from this service shall be used to offset expenses to provide the service. Any balance of this revenue collected and unexpended at the end of the fiscal year shall revert to the appropriate restricted fund.

Free health clinics; allocation; use of volunteer health professionals.

Sec. 712. From the funds appropriated in part 1 for primary care services, $250,000.00 shall be allocated to free health clinics operating in the state. The department shall distribute the funds equally to each free health clinic. For the purpose of this appropriation, free health clinics are nonprofit organizations that use volunteer health professionals to provide care to uninsured individuals.

Multicultural agencies providing primary care services.

Sec. 713. The department is directed to continue support of multicultural agencies that provide primary care services from the funds appropriated in part 1.

Nursing facility complaint investigations; report.

Sec. 714. The department shall report to the legislature on the timeliness of nursing facility complaint investigations and the number of complaints that are substantiated on an annual basis. The report shall consist of the number of complaints filed by consumers and the number of facility-reported incidents. The department shall make every effort to contact every complainant and the subject of a complaint during an investigation.

Nonurgent medical response service; pilot program in city of Detroit.

Sec. 715. From the funds appropriated in part 1 for primary care services, $100.00 is appropriated for the department to establish a pilot program in the city of Detroit for a nonurgent medical response service.

Investigations of alleged wrongdoing by licensed health care professionals; priority.

Sec. 716. The department shall give priority in investigations of alleged wrongdoing by licensed health care professionals to instances that are alleged to have occurred within 2 years of the initial complaint.

HealthKey program for uninsured.

Sec. 717. From the funds appropriated in part 1 for primary care services, $100.00 shall be allocated for the HealthKey program for the uninsured.

INFECTIOUS DISEASE CONTROL

AIDS programs; priority for services to high-risk individuals ages 9 through 18.

Sec. 801. In the expenditure of funds appropriated in part 1 for AIDS programs, the department and its subcontractors shall ensure that high-risk individuals ages 9 through 18 shall receive priority for prevention, education, and outreach services.

AIDS provider education activities; funding to Michigan state medical society.

Sec. 802. In developing and implementing AIDS provider education activities, the department may provide funding to the Michigan state medical society to serve as lead agency to convene a consortium of health care providers, to design needed educational efforts, to fund other statewide provider groups, and to assure implementation of these efforts, in accordance with a plan approved by the department.

AIDS drug assistance program.

Sec. 803. The department shall continue the AIDS drug assistance program maintaining the prior year eligibility criteria and drug formulary. This section is not intended to prohibit the department from providing assistance for improved AIDS treatment medications. If the appropriation in part 1 or actual revenue is not sufficient to maintain the prior year eligibility criteria and drug formulary, the department may revise the eligibility criteria and drug formulary in a manner that is consistent with federal program guidelines.

Michigan prisoner reentry initiative; prisoners released who are HIV positive or positive for Hepatitis C antibody.

Sec. 804. The department, in conjunction with efforts to implement the Michigan prisoner reentry initiative, shall cooperate with the department of corrections to share data and information as they relate to prisoners being released who are HIV positive or positive for the Hepatitis C antibody. By April 1, 2008, the department shall report to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the progress and results of its work as permitted under federal law and the potential outcomes from its work with the department of corrections under this section.

Childhood recommended vaccines; allocation of funds.

Sec. 806. If funds become available, up to $100,000.00 may be allocated for the purchase of childhood recommended vaccines for the underinsured population ages birth through 18 years of age.

EPIDEMIOLOGY

Lead abatement program.

Sec. 851. The department shall provide a report annually to the house of representatives and senate appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the expenditures and activities undertaken by the lead abatement program. The report shall include, but is not limited to, a funding allocation schedule, expenditures by category of expenditure and by subcontractor, revenues received, description of program elements, and description of program accomplishments and progress.

LOCAL HEALTH ADMINISTRATION AND GRANTS

Implementation of MCL 333.17015; reimbursement to local health departments for costs incurred.

Sec. 901. The amount appropriated in part 1 for implementation of the 1993 amendments to sections 9161, 16221, 16226, 17014, 17015, and 17515 of the public health code, 1978 PA 368, MCL 333.9161, 333.16221, 333.16226, 333.17014, 333.17015, and 333.17515, shall reimburse local health departments for costs incurred related to implementation of section 17015(18) of the public health code, 1978 PA 368, MCL 333.17015.

County ceasing to participate in district health department arrangement; penalty.

Sec. 902. If a county that has participated in a district health department or an associated arrangement with other local health departments takes action to cease to participate in such an arrangement after October 1, 2007, the department shall have the authority to assess a penalty from the local health department's operational accounts in an amount equal to no more than 6.25% of the local health department's local public health operations funding. This penalty shall only be assessed to the local county that requests the dissolution of the health department.

Immunizations, infectious disease control, sexually transmitted disease control and prevention, hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management; allocations to local public health operations; report.

Sec. 904. (1) Funds appropriated in part 1 for local public health operations shall be prospectively allocated to local health departments to support immunizations, infectious disease control, sexually transmitted disease control and prevention, hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management. Food protection shall be provided in consultation with the Michigan department of agriculture. Public water supply, private groundwater supply, and on-site sewage management shall be provided in consultation with the Michigan department of environmental quality.

(2) Local public health departments will be held to contractual standards for the services in subsection (1).

(3) Distributions in subsection (1) shall be made only to counties that maintain local spending in fiscal year 2007-2008 of at least the amount expended in fiscal year 1992-1993 for the services described in subsection (1).

(4) By April 1, 2008, the department shall make available a report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the planned allocation of the funds appropriated for local public health operations.

Hearing and vision screening services.

Sec. 905. From the funds appropriated in part 1 for local public health operations, $5,150,000.00 shall be used to continue funding hearing and vision screening services through local public health departments.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Alzheimer's information network; referral services; use of funds.

Sec. 1003. Funds appropriated in part 1 for the Alzheimer's information network shall be used to provide information and referral services through regional networks for persons with Alzheimer's disease or related disorders, their families, and health care providers.

Smoking prevention program; priority; use of funds for quit kit program.

Sec. 1006. (1) In spending the funds appropriated in part 1 for the smoking prevention program, priority shall be given to prevention and smoking cessation programs for pregnant women, women with young children, and adolescents.

(2) For purposes of complying with 2004 PA 164, $900,000.00 of the funds appropriated in part 1 for the smoking prevention program shall be used for the quit kit program that includes the nicotine patch or nicotine gum.

Violence prevention.

Sec. 1007. (1) The funds appropriated in part 1 for violence prevention shall be used for, but not be limited to, the following:

(a) Programs aimed at the prevention of spouse, partner, or child abuse and rape.

(b) Programs aimed at the prevention of workplace violence.

(2) In awarding grants from the amounts appropriated in part 1 for violence prevention, the department shall give equal consideration to public and private nonprofit applicants.

(3) From the funds appropriated in part 1 for violence prevention, the department may include local school districts as recipients of the funds for family violence prevention programs.

Diabetes and kidney program; allocation of funds.

Sec. 1009. From the funds appropriated in part 1 for the diabetes and kidney program, a portion of the funds may be allocated to the National Kidney Foundation of Michigan for kidney disease prevention programming including early identification and education programs and kidney disease prevention demonstration projects.

Chronic disease prevention; allocation for osteoporosis prevention and treatment education.

Sec. 1010. From the funds appropriated in part 1 for chronic disease prevention, $200,000.00 shall be allocated for osteoporosis prevention and treatment education.

Chronic disease prevention; stroke prevention, education, and outreach.

Sec. 1019. From the funds appropriated in part 1 for chronic disease prevention, $50,000.00 may be allocated for stroke prevention, education, and outreach. The objectives of the program shall include education to assist persons in identifying risk factors, and education to assist persons in the early identification of the occurrence of a stroke in order to minimize stroke damage.

African-American male health initiative.

Sec. 1028. Contingent on the availability of state restricted healthy Michigan fund money or federal preventive health and health services block grant fund money, funds may be appropriated for the African-American male health initiative.

Treatment guideline for traumatic brain injury; incentive-based pilot program.

Sec. 1031. (1) From the funds appropriated in part 1 for the injury control intervention project, $100.00 shall be used to establish an incentive-based pilot program for level I and level II trauma hospitals to ensure greater state utilization of an interactive, evidence-based treatment guideline model for traumatic brain injury.

(2) This pilot program shall be placed in a county with a population between 175,000 and 200,000.

FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES

Women, infants, and children food supplement program, family planning, and prenatal care outreach and service delivery support program.

Sec. 1101. The department shall review the basis for the distribution of funds to local health departments and other public and private agencies for the women, infants, and children food supplement program; family planning; and prenatal care outreach and service delivery support program and indicate the basis upon which any projected underexpenditures by local public and private agencies shall be reallocated to other local agencies that demonstrate need.

Report.

Sec. 1104. (1) Before April 1, 2008, the department shall submit a report to the house and senate fiscal agencies and the state budget director on planned allocations from the amounts appropriated in part 1 for local MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs. Using applicable federal definitions, the report shall include information on all of the following:

(a) Funding allocations.

(b) Actual number of women, children, and/or adolescents served and amounts expended for each group for the fiscal year 2006-2007.

(c) Beginning with the report due in fiscal year 2008-2009, a breakdown of the expenditure of these funds between urban and rural communities. The department shall begin collecting the data necessary to provide this breakdown in fiscal year 2007-2008.

(2) The department shall ensure that the distribution of funds through the programs described in subsection (1) takes into account the needs of rural communities.

(3) For the purposes of this section, "rural" means a county, city, village, or township with a population of not more than 30,000, including those entities if located within a metropolitan statistical area.

Contracts with local agencies; factors.

Sec. 1105. For all programs for which an appropriation is made in part 1, the department shall contract with those local agencies best able to serve clients. Factors to be used by the department in evaluating agencies under this section shall include ability to serve high-risk population groups; ability to provide access to individuals in need of services in rural communities; ability to serve low-income clients, where applicable; availability of, and access to, service sites; management efficiency; and ability to meet federal standards, when applicable.

Family planning programs; compliance with performance and quality assurance indicators required.

Sec. 1106. Each family planning program receiving federal title X family planning funds shall be in compliance with all performance and quality assurance indicators that the United States bureau of community health services specifies in the family planning annual report. An agency not in compliance with the indicators shall not receive supplemental or reallocated funds.

Prenatal care outreach and service delivery support.

Sec. 1107. Of the amount appropriated in part 1 for prenatal care outreach and service delivery support, not more than 9% shall be expended for local administration, data processing, and evaluation.

Pregnancy prevention programs; use of funds to provide abortion counseling, referrals, or services prohibited.

Sec. 1108. The funds appropriated in part 1 for pregnancy prevention programs shall not be used to provide abortion counseling, referrals, or services.

Volunteer dental program; report.

Sec. 1109. (1) From the amounts appropriated in part 1 for dental programs, funds shall be allocated to the Michigan dental association for the administration of a volunteer dental program that shall provide dental services to the uninsured in an amount that is no less than the amount allocated to that program in fiscal year 1996-1997.

(2) Not later than December 1 of the current fiscal year, the department shall make available upon request a report to the senate or house of representatives appropriations subcommittee on community health or the senate or house of representatives standing committee on health policy the number of individual patients treated, number of procedures performed, and approximate total market value of those procedures through September 30, 2007.

Agencies receiving family planning funds; designation as delegate agencies.

Sec. 1110. Agencies that currently receive pregnancy prevention funds and either receive or are eligible for other family planning funds shall have the option of receiving all of their family planning funds directly from the department of community health and be designated as delegate agencies.

Family planning/pregnancy prevention services.

Sec. 1111. The department shall allocate no less than 88% of the funds appropriated in part 1 for family planning local agreements and the pregnancy prevention program for the direct provision of family planning/pregnancy prevention services.

Communities with high infant mortality rates; allocation.

Sec. 1112. From the funds appropriated in part 1 for prenatal care outreach and service delivery support, the department shall allocate at least $1,000,000.00 to communities with high infant mortality rates.

Children with elevated blood lead levels; report.

Sec. 1129. The department shall provide a report annually to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on the number of children with elevated blood lead levels from information available to the department. The report shall provide the information by county, shall include the level of blood lead reported, and shall indicate the sources of the information.

Nurse family partnership program.

Sec. 1132. From the funds appropriated in part 1 for special projects, $400,000.00 shall be allocated to the nurse family partnership program.

Infant mortality rate data; release.

Sec. 1133. The department shall release infant mortality rate data to all local public health departments 72 hours or more before releasing infant mortality rate data to the public.

Michigan model for comprehensive school health education state steering committee; school health education curriculum in accordance with goals; informing pupil or parent of content of course.

Sec. 1135. (1) Provision of the school health education curriculum, such as the Michigan model or another comprehensive school health education curriculum, shall be in accordance

with the health education goals established by the Michigan model for the comprehensive school health education state steering committee. The state steering committee shall be comprised of a representative from each of the following offices and departments:

(a) The department of education.

(b) The department of community health.

(c) The health administration in the department of community health.

(d) The bureau of mental health and substance abuse services in the department of community health.

(e) The department of human services.

(f) The department of state police.

(2) Upon written or oral request, a pupil not less than 18 years of age or a parent or legal guardian of a pupil less than 18 years of age, within a reasonable period of time after the request is made, shall be informed of the content of a course in the health education curriculum and may examine textbooks and other classroom materials that are provided to the pupil or materials that are presented to the pupil in the classroom. This subsection does not require a school board to permit pupil or parental examination of test questions and answers, scoring keys, or other examination instruments or data used to administer an academic examination.

WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Project FRESH; local annual contributions.

Sec. 1151. The department may work with local participating agencies to define local annual contributions for the farmer's market nutrition program, project FRESH, to enable the department to request federal matching funds based on local commitment of funds.

Lead screening testing required; conditions.

Sec. 1152. The department shall require that all Medicaid children participating in the special supplemental food program for women, infants, and children receive lead screening testing.

Access to WIC program by residents of rural communities.

Sec. 1153. The department shall ensure that individuals residing in rural communities have sufficient access to the services offered through the WIC program.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

Children with special health care needs; payment of funds.

Sec. 1201. Funds appropriated in part 1 for medical care and treatment of children with special health care needs shall be paid according to reimbursement policies determined by the Michigan medical services program. Exceptions to these policies may be taken with the prior approval of the state budget director.

Powers of department to provide certain services.

Sec. 1202. The department may do 1 or more of the following:

(a) Provide special formula for eligible clients with specified metabolic and allergic disorders.

(b) Provide medical care and treatment to eligible patients with cystic fibrosis who are 21 years of age or older.

(c) Provide genetic diagnostic and counseling services for eligible families.

(d) Provide medical care and treatment to eligible patients with hereditary coagulation defects, commonly known as hemophilia, who are 21 years of age or older.

Children's special health care services program; referral to locally based services program.

Sec. 1203. All children who are determined medically eligible for the children's special health care services program shall be referred to the appropriate locally based services program in their community.

OFFICE OF DRUG CONTROL POLICY

Byrne formula grant program.

Sec. 1250. The department shall provide $1,800,000.00 in Byrne formula grant program funding to the judiciary by interdepartmental grant.

CRIME VICTIM SERVICES COMMISSION

Forensic nurse examiner programs.

Sec. 1302. From the funds appropriated in part 1 for justice assistance grants, up to $50,000.00 shall be allocated for expansion of forensic nurse examiner programs to facilitate training for improved evidence collection for the prosecution of sexual assault. The funds shall be used for program coordination, training, and counseling. Unexpended funds shall be carried forward.

"Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims"; collection of evidence.

Sec. 1304. The department shall work with the department of state police, the Michigan hospital association, the Michigan state medical society, and the Michigan nurses association to ensure that the recommendations included in the "Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims" are followed in the collection of evidence.

OFFICE OF SERVICES TO THE AGING

Community and nutrition services and home services; restriction.

Sec. 1401. The appropriation in part 1 to the office of services to the aging, for community and nutrition services and home services, shall be restricted to eligible individuals at least 60 years of age who fail to qualify for home care services under title XVIII, XIX, or XX.

Home delivered meals.

Sec. 1403. (1) The office of services to the aging shall require each region to report to the office of services to the aging home delivered meals waiting lists based upon standard criteria. Determining criteria shall include all of the following:

(a) The recipient's degree of frailty.

(b) The recipient's inability to prepare his or her own meals safely.

(c) Whether the recipient has another care provider available.

(d) Any other qualifications normally necessary for the recipient to receive home delivered meals.

(2) Data required in subsection (1) shall be recorded only for individuals who have applied for participation in the home delivered meals program and who are initially determined as likely to be eligible for home delivered meals.

Day care, care management, respite care, and certain eligible home- and community-based services; fees.

Sec. 1404. The area agencies and local providers may receive and expend fees for the provision of day care, care management, respite care, and certain eligible home- and community-based services. The fees shall be based on a sliding scale, taking client income into consideration. The fees shall be used to expand services.

Respite care program.

Sec. 1406. The appropriation of $5,000,000.00 of merit award trust funds to the office of services to the aging for the respite care program shall be allocated in accordance with a long-term care plan developed by the long-term care working group established in section 1657 of 1998 PA 336 upon implementation of the plan. The use of the funds shall be for direct respite care or adult respite care center services. Not more than 9% of the amount allocated under this section shall be expended for administration and administrative purposes.

Locally-based services; commitment of legislature.

Sec. 1413. The legislature affirms the commitment to locally-based services. The legislature supports the role of local county board of commissioners in the approval of area agency on aging plans. Local counties may request to change membership in the area agencies on aging if the change is to an area agency on aging that is contiguous to that county pursuant to office of services to the aging policies and procedures for area agency on aging designation. The department shall adjust allocations to area agencies on aging to account for any changes in county membership. The department shall ensure annually that county boards of commissioners are aware that county membership in area agencies on aging can be changed subject to office of services to the aging policies and procedures for area agency on aging designation. The legislature supports the office of services to the aging working with others to provide training to commissioners to better understand and advocate for aging issues. It is the intent of the legislature to prohibit area agencies on aging from providing direct services, other than access services, unless the agencies receive a waiver from the commission on services to the aging. The legislature's intent in this section is conditioned on compliance with federal and state laws, rules, and policies.

In-home services, resources, and assistance to frail elderly.

Sec. 1416. The legislature strongly affirms its commitment to provide in-home services, resources, and assistance for the frail elderly who are not being served by the Medicaid home- and community-based services waiver program.

Report.

Sec. 1417. The department shall provide to the senate and house of representatives appropriations subcommittees on community health, senate and house fiscal agencies, and state budget director a report by March 30, 2008 that contains all of the following:

(a) The total allocation of state resources made to each area agency on aging by individual program and administration.

(b) Detail expenditure by each area agency on aging by individual program and administration including both state funded resources and locally funded resources.

MICHIGAN FIRST HEALTHCARE PLAN

Michigan first healthcare plan; waiver required.

Sec. 1501. (1) Funds appropriated in part 1 for the Michigan first healthcare plan are contingent upon approval of a waiver from the federal government.

(2) In addition to the funds appropriated in part 1 for the Michigan first healthcare plan, up to $300,000,000.00 in federal funds shall be appropriated upon approval of a waiver from the federal government.

Michigan first healthcare plan; report.

Sec. 1502. Upon approval of a waiver from the federal government for the Michigan first healthcare plan, the department shall provide the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director with a report detailing the process that will be utilized to determine which insurance entities will be selected for participation in the Michigan first healthcare plan. The department shall not award a single-source contract to a health plan through the Michigan first healthcare plan.

Michigan first healthcare plan; providing proposal to legislature and state budget director.

Sec. 1503. The department shall provide a copy of the federally approved Michigan first healthcare plan or similar proposal to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director at least 60 days before implementing any portion of the Michigan first healthcare plan or other similar proposal.

MEDICAL SERVICES

Remedial services.

Sec. 1601. The cost of remedial services incurred by residents of licensed adult foster care homes and licensed homes for the aged shall be used in determining financial eligibility for the medically needy. Remedial services include basic self-care and rehabilitation training for a resident.

Medical services to elderly and disabled persons.

Sec. 1602. Medical services shall be provided to elderly and disabled persons with incomes less than or equal to 100% of the official poverty level, pursuant to the state's option to elect such coverage set out at section 1902(a)(10)(A)(*ii*) and (m) of title XIX, 42 USC 1396a.

Medical coverage; purchase.

Sec. 1603. (1) The department may establish a program for persons to purchase medical coverage at a rate determined by the department.

(2) The department may receive and expend premiums for the buy-in of medical coverage in addition to the amounts appropriated in part 1.

(3) The premiums described in this section shall be classified as private funds.

Medicaid covered and authorized services; payment; "completed application" defined.

Sec. 1604. If an applicant for Medicaid coverage is found to be eligible, the department shall provide payment for all of the Medicaid covered and appropriately authorized services that have been provided to that applicant since the first day of the month in which the applicant filed and the department of human services received the application for Medicaid coverage. Receipt of the application by a local department of human services office is considered the date the application is received. If an application is submitted on the last day of the month and that day falls on a weekend or a holiday and the application is received by the local department of human services office on the first business day following the end of the month, then receipt of the application is considered to have been on the last day of the previous month. As used in this section, "completed application" means an application complete on its face and signed by the applicant regardless of whether the medical documentation required to make an eligibility determination is included.

Medicaid coverage; protected income level.

Sec. 1605. (1) The protected income level for Medicaid coverage determined pursuant to section 106(1)(b)(*iii*) of the social welfare act, 1939 PA 280, MCL 400.106, shall be 100% of the related public assistance standard.

(2) The department shall notify the senate and house of representatives appropriations subcommittees on community health and the state budget director of any proposed revisions to the protected income level for Medicaid coverage related to the public assistance standard 90 days prior to implementation.

Guardian and conservator charges; deduction as allowable expense.

Sec. 1606. For the purpose of guardian and conservator charges, the department of community health may deduct up to $60.00 per month as an allowable expense against a recipient's income when determining medical services eligibility and patient pay amounts.

Pregnancy services.

Sec. 1607. (1) An applicant for Medicaid, whose qualifying condition is pregnancy, shall immediately be presumed to be eligible for Medicaid coverage unless the preponderance of evidence in her application indicates otherwise. The applicant who is qualified as described in this subsection shall be allowed to select or remain with the Medicaid participating obstetrician of her choice.

(2) An applicant qualified as described in subsection (1) shall be given a letter of authorization to receive Medicaid covered services related to her pregnancy. All qualifying applicants shall be entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from a health plan. All claims submitted for payment for obstetrical and

prenatal care shall be paid at the Medicaid fee-for-service rate in the event a contract does not exist between the Medicaid participating obstetrical or prenatal care provider and the managed care plan. The applicant shall receive a listing of Medicaid physicians and managed care plans in the immediate vicinity of the applicant's residence.

(3) In the event that an applicant, presumed to be eligible pursuant to subsection (1), is subsequently found to be ineligible, a Medicaid physician or managed care plan that has been providing pregnancy services to an applicant under this section is entitled to reimbursement for those services until such time as they are notified by the department that the applicant was found to be ineligible for Medicaid.

(4) If the preponderance of evidence in an application indicates that the applicant is not eligible for Medicaid, the department shall refer that applicant to the nearest public health clinic or similar entity as a potential source for receiving pregnancy-related services.

(5) The department shall develop an enrollment process for pregnant women covered under this section that facilitates the selection of a managed care plan at the time of application.

Cost report grievances by medical services providers.

Sec. 1610. The department of community health shall provide an administrative procedure for the review of cost report grievances by medical services providers with regard to reimbursement under the medical services program. Settlements of properly submitted cost reports shall be paid not later than 9 months from receipt of the final report.

Medical services reimbursement; recipients with other third-party sources of payment; hospital services to Medicare/medical services recipients with Medicare part B coverage.

Sec. 1611. (1) For care provided to medical services recipients with other third-party sources of payment, medical services reimbursement shall not exceed, in combination with such other resources, including Medicare, those amounts established for medical services-only patients. The medical services payment rate shall be accepted as payment in full. Other than an approved medical services copayment, no portion of a provider's charge shall be billed to the recipient or any person acting on behalf of the recipient. Nothing in this section shall be considered to affect the level of payment from a third-party source other than the medical services program. The department shall require a nonenrolled provider to accept medical services payments as payment in full.

(2) Notwithstanding subsection (1), medical services reimbursement for hospital services provided to dual Medicare/medical services recipients with Medicare part B coverage only shall equal, when combined with payments for Medicare and other third-party resources, if any, those amounts established for medical services-only patients, including capital payments.

Pharmaceutical dispensing fee; prescription copayment; savings from multiple source generic medication dispensing.

Sec. 1620. (1) For fee-for-service recipients who do not reside in nursing homes, the pharmaceutical dispensing fee shall be $2.50 or the pharmacy's usual or customary cash charge, whichever is less. For nursing home residents, the pharmaceutical dispensing fee shall be $2.75 or the pharmacy's usual or customary cash charge, whichever is less.

(2) The department shall require a prescription copayment for Medicaid recipients of $1.00 for a generic drug and $3.00 for a brand-name drug, except as prohibited by federal or state law or regulation.

(3) It is the intent of the legislature that if the department realizes savings as a result of the implementation of average manufacturer's price for reimbursement of multiple source generic medication dispensing as imposed pursuant to the federal deficit reduction act of 2005, Public Law 109-171, the savings shall be returned to pharmacies in the form of an increased dispensing fee for medications not to exceed $2.00. The savings shall be calculated as the difference in state expenditure between the current methodology of payment, which is maximum allowable cost, and the proposed new reimbursement method of average manufacturer's price.

Prospective drug utilization review and disease management systems.

Sec. 1621. The department may implement prospective drug utilization review and disease management systems. The prospective drug utilization review and disease management systems authorized by this section shall have physician oversight, shall focus on patient, physician, and pharmacist education, and shall be developed in consultation with the national pharmaceutical council, Michigan state medical society, Michigan association of osteopathic physicians, Michigan pharmacists association, Michigan health and hospital association, and Michigan nurses' association.

Dispensing 100-day supply for maintenance drugs.

Sec. 1623. (1) The department shall continue the Medicaid policy that allows for the dispensing of a 100-day supply for maintenance drugs.

(2) The department shall notify all HMOs, physicians, pharmacies, and other medical providers that are enrolled in the Medicaid program that Medicaid policy allows for the dispensing of a 100-day supply for maintenance drugs.

(3) The notice in subsection (2) shall also clarify that a pharmacy shall fill a prescription written for maintenance drugs in the quantity specified by the physician, but not more than the maximum allowed under Medicaid, unless subsequent consultation with the prescribing physician indicates otherwise.

Medicaid preferred drug list; placement of atypical antipsychotic medications.

Sec. 1625. The department shall continue its practice of placing all atypical antipsychotic medications on the Medicaid preferred drug list.

Quarterly rebates from pharmaceutical manufacturers for outpatient drugs.

Sec. 1627. (1) The department shall use procedures and rebates amounts specified under section 1927 of title XIX, 42 USC 1396r-8, to secure quarterly rebates from pharmaceutical manufacturers for outpatient drugs dispensed to participants in the MIChild program, maternal outpatient medical services program, children's special health care services, and adult benefit waiver program.

(2) For products distributed by pharmaceutical manufacturers not providing quarterly rebates as listed in subsection (1), the department may require preauthorization.

Wholesaler pricing.

Sec. 1629. The department shall utilize maximum allowable cost pricing for generic drugs that is based on wholesaler pricing to providers that is available from at least 2 wholesalers who deliver in the state of Michigan.

Podiatric services, adult dental services, and chiropractic services; bulk purchase of hearing aids.

Sec. 1630. (1) Medicaid coverage for podiatric services, adult dental services, and chiropractic services shall continue at not less than the level in effect on October 1, 2002, except that reasonable utilization limitations may be adopted in order to prevent excess utilization. The department shall not impose utilization restrictions on chiropractic services unless a recipient has exceeded 18 office visits within 1 year.

(2) The department may implement the bulk purchase of hearing aids, impose limitations on binaural hearing aid benefits, and limit the replacement of hearing aids to once every 3 years.

Dental, podiatric, chiropractic, vision, and hearing aid services; copayments.

Sec. 1631. (1) The department shall require copayments on dental, podiatric, chiropractic, vision, and hearing aid services provided to Medicaid recipients, except as prohibited by federal or state law or regulation.

(2) Except as otherwise prohibited by federal or state law or regulations, the department shall require Medicaid recipients to pay the following copayments:

(a) Two dollars for a physician office visit.

(b) Three dollars for a hospital emergency room visit.

(c) Fifty dollars for the first day of an inpatient hospital stay.

(d) One dollar for an outpatient hospital visit.

Healthy kids dental program to Genesee county and Saginaw county.

Sec. 1633. From the funds appropriated in part 1 for dental services, the department shall allocate $2,625,300.00 to expand the healthy kids dental program to Genesee County and Saginaw County.

Ambulance services.

Sec. 1634. From the funds appropriated in part 1 for ambulance services, the department shall continue the 5% increase in payment rates for ambulance services implemented in fiscal year 2000-2001 and continue the ground mileage reimbursement rate per statute mile at $4.25.

Obstetrical services.

Sec. 1635. From the funds appropriated in part 1 for physician services and health plan services, the department shall continue the increase in Medicaid reimbursement rates for obstetrical services implemented in fiscal year 2005-2006.

Physician well child procedure codes and primary care procedure codes; increased reimbursement rates.

Sec. 1636. From the funds appropriated in part 1 for physician services and health plan services, the department shall continue the increase in Medicaid reimbursement rates for physician well child procedure codes and primary care procedure codes implemented in fiscal year 2006-2007. The increased reimbursement rates in this section shall not exceed the comparable Medicare payment rate for the same services.

Medicaid personal responsibility agreement.

Sec. 1637. (1) All adult Medicaid recipients shall be offered the opportunity to sign a Medicaid personal responsibility agreement.

(2) The personal responsibility agreement shall include at minimum the following provisions:

(a) That the recipient shall not smoke.

(b) That the recipient shall attend all scheduled medical appointments.

(c) That the recipient shall exercise regularly.

(d) That if the recipient has children, those children shall be up to date on their immunizations.

(e) That the recipient shall abstain from abusing controlled substances and narcotics.

Submission of cost reports; time period.

Sec. 1641. An institutional provider that is required to submit a cost report under the medical services program shall submit cost reports completed in full within 5 months after the end of its fiscal year.

Psychiatric residency training program.

Sec. 1643. Of the funds appropriated in part 1 for graduate medical education in the hospital services and therapy line-item appropriation, not less than $10,359,000.00 shall be allocated for the psychiatric residency training program that establishes and maintains collaborative relations with the schools of medicine at Michigan State University and Wayne State University if the necessary allowable Medicaid matching funds are provided by the universities.

Graduate medical education.

Sec. 1647. From the funds appropriated in part 1 for medical services, the department shall allocate for graduate medical education not less than the level of rates and payments in effect on April 1, 2005.

Enrollment and benefit information of Medicaid recipients; toll-free telephone line or online resource.

Sec. 1648. The department shall maintain an automated toll-free telephone line and make available an online resource to enable medical providers to obtain enrollment and benefit information of Medicaid recipients. There shall be no charge to providers for the use of the toll-free telephone line or online resource.

Breast and cervical cancer treatment coverage.

Sec. 1649. From the funds appropriated in part 1 for medical services, the department shall continue breast and cervical cancer treatment coverage for women up to 250% of the federal poverty level, who are under age 65, and who are not otherwise covered by insurance. This coverage shall be provided to women who have been screened through the centers for disease control breast and cervical cancer early detection program, and are found to have breast or cervical cancer, pursuant to the breast and cervical cancer prevention and treatment act of 2000, Public Law 106-354, 114 Stat. 1381.

Managed care plan; preference; notice to persons assigned managed care provider; exceptions.

Sec. 1650. (1) The department may require medical services recipients residing in counties offering managed care options to choose the particular managed care plan in which they wish to be enrolled. Persons not expressing a preference may be assigned to a managed care provider.

(2) Persons to be assigned a managed care provider shall be informed in writing of the criteria for exceptions to capitated managed care enrollment, their right to change HMOs

for any reason within the initial 90 days of enrollment, the toll-free telephone number for problems and complaints, and information regarding grievance and appeals rights.

(3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to mandatory enrollment at least through the current prescribed course of treatment, subject to periodic review of continued eligibility.

Hospice services.

Sec. 1651. (1) Medical services patients who are enrolled in HMOs have the choice to elect hospice services or other services for the terminally ill that are offered by the HMOs. If the patient elects hospice services, those services shall be provided in accordance with part 214 of the public health code, 1978 PA 368, MCL 333.21401 to 333.21420.

(2) The department shall not amend the medical services hospice manual in a manner that would allow hospice services to be provided without making available all comprehensive hospice services described in 42 CFR 418.

Expansion of service area by HMO; agreement.

Sec. 1652. If the department implements changes in the Medicaid health plan contract to permit contracted HMOs to request service area expansions, it shall ensure that any Medicaid health plan that expands its service area agrees to the following:

(a) The Medicaid HMO shall not sell, transfer, or otherwise convey to any person all or any portion of the HMO's assets or business, whether in the form of equity, debt or otherwise, for a period of 3 years from the date the Medicaid HMO commences operations in a new service area.

(b) That any Medicaid HMOs that expand into a county with a population of at least 1,500,000 shall also expand its coverage to a county with a population of less than 100,000 which has 1 or fewer HMOs participating in the Medicaid program.

Managed care; implementation and contracting; conditions.

Sec. 1653. Implementation and contracting for managed care by the department through HMOs shall be subject to the following conditions:

(a) Continuity of care is assured by allowing enrollees to continue receiving required medically necessary services from their current providers for a period not to exceed 1 year if enrollees meet the managed care medical exception criteria.

(b) The department shall require contracted HMOs to submit data determined necessary for evaluation on a timely basis.

(c) Mandatory enrollment of Medicaid beneficiaries living in counties defined as rural by the federal government, which is any nonurban standard metropolitan statistical area, is allowed if there is only 1 HMO serving the Medicaid population, as long as each Medicaid beneficiary is assured of having a choice of at least 2 physicians by the HMO.

(d) Enrollment of recipients of children's special health care services in HMOs shall be voluntary during the fiscal year.

(e) The department shall develop a case adjustment to its rate methodology that considers the costs of persons with HIV/AIDS, end stage renal disease, organ transplants, and other high-cost diseases or conditions and shall implement the case adjustment when it is proven to be actuarially and fiscally sound. Implementation of the case adjustment must be budget neutral.

Services delivered other than through HMO provider; conditions for reimbursement.

Sec. 1654. Medicaid HMOs shall provide for reimbursement of HMO covered services delivered other than through the HMO's providers if medically necessary and approved by the HMO, immediately required, and that could not be reasonably obtained through the HMO's providers on a timely basis. Such services shall be considered approved if the HMO does not respond to a request for authorization within 24 hours of the request. Reimbursement shall not exceed the Medicaid fee-for-service payment for those services.

Lock-in period; exceptions; change.

Sec. 1655. (1) The department may require a 12-month lock-in to the HMO selected by the recipient during the initial and subsequent open enrollment periods, but allow for good cause exceptions during the lock-in period.

(2) Medicaid recipients shall be allowed to change HMOs for any reason within the initial 90 days of enrollment.

Expedited complaint review procedure.

Sec. 1656. (1) The department shall provide an expedited complaint review procedure for Medicaid eligible persons enrolled in HMOs for situations in which failure to receive any health care service would result in significant harm to the enrollee.

(2) The department shall provide for a toll-free telephone number for Medicaid recipients enrolled in managed care to assist with resolving problems and complaints. If warranted, the department shall immediately disenroll persons from managed care and approve fee-for-service coverage.

Screening and stabilizing Medicaid recipient; discharge from emergency room; report.

Sec. 1657. (1) Reimbursement for medical services to screen and stabilize a Medicaid recipient, including stabilization of a psychiatric crisis, in a hospital emergency room shall not be made contingent on obtaining prior authorization from the recipient's HMO. If the recipient is discharged from the emergency room, the hospital shall notify the recipient's HMO within 24 hours of the diagnosis and treatment received.

(2) If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's HMO prior to admitting the recipient.

(3) Subsections (1) and (2) shall not be construed as a requirement to alter an existing agreement between an HMO and their contracting hospitals nor as a requirement that an HMO must reimburse for services that are not considered to be medically necessary.

(4) Prior to contracting with an HMO for managed care services that did not have a contract with the department before October 1, 2002, the department shall receive assurances from the office of financial and insurance services that the HMO meets the net worth and financial solvency requirements contained in chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580.

(5) The department shall provide a report by September 30, 2008 to the senate and house appropriations subcommittees on community health and senate and house fiscal agencies examining how payment policies in the current Medicaid program create financial incentives for health facilities to admit recipients from the emergency room.

Hospital access agreement.

Sec. 1658. (1) HMOs shall have contracts with hospitals within a reasonable distance from their enrollees. If a hospital does not contract with the HMO in its service area, that hospital shall enter into a hospital access agreement as specified in the MSA bulletin Hospital 01-19.

(2) A hospital access agreement specified in subsection (1) shall be considered an affiliated provider contract pursuant to the requirements contained in chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580.

Sections applicable to Medicaid managed care programs.

Sec. 1659. The following sections of this act are the only ones that shall apply to the following Medicaid managed care programs, including the comprehensive plan, MIChoice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 401, 402, 404, 411, 414, 418, 424, 428, 456, 1650, 1651, 1652, 1653, 1654, 1655, 1656, 1657, 1658, 1660, 1661, 1662, 1666, 1699, 1711, 1749, and 1752.

EPSDT services.

Sec. 1660. (1) The department shall assure that all Medicaid children have timely access to EPSDT services as required by federal law. Medicaid HMOs shall provide EPSDT services to their child members in accordance with Medicaid EPSDT policy.

(2) The primary responsibility of assuring a child's hearing and vision screening is with the child's primary care provider. The primary care provider shall provide age-appropriate screening or arrange for these tests through referrals to local health departments. Local health departments shall provide preschool hearing and vision screening services and accept referrals for these tests from physicians or from Head Start programs in order to assure all preschool children have appropriate access to hearing and vision screening. Local health departments shall be reimbursed for the cost of providing these tests for Medicaid eligible children by the Medicaid program.

(3) The department shall require Medicaid HMOs to provide EPSDT utilization data through the encounter data system, and health employer data and information set well child health measures in accordance with the National Committee on Quality Assurance prescribed methodology.

(4) The department shall require HMOs to be responsible for well child visits and maternal and infant support services as described in Medicaid policy. These responsibilities shall be specified in the information distributed by the HMOs to their members.

(5) The department shall provide, on an annual basis, budget neutral incentives to Medicaid HMOs and local health departments to improve performance on measures related to the care of children and pregnant women.

MSS/ISS services.

Sec. 1661. (1) The department shall assure that all Medicaid eligible children and pregnant women have timely access to MSS/ISS services. Medicaid HMOs shall assure that maternal support service screening is available to their pregnant members and that those women found to meet the maternal support service high-risk criteria are offered maternal support services. Local health departments shall assure that maternal support service screening is available for Medicaid pregnant women not enrolled in an HMO and that those women found to meet the maternal support service high-risk criteria are offered maternal support services or are referred to a certified maternal support service provider.

(2) The department shall prohibit HMOs from requiring prior authorization of their contracted providers for any EPSDT screening and diagnosis service, for any MSS/ISS screening referral, or for up to 3 MSS/ISS service visits.

(3) The department shall assure the coordination of MSS/ISS services with the WIC program, state-supported substance abuse, smoking prevention, and violence prevention programs, the department of human services, and any other state or local program with a focus on preventing adverse birth outcomes and child abuse and neglect.

External quality review; copy of analysis and reports; improvement of service delivery and coordination in MSS/ISS and EPSDT programs.

Sec. 1662. (1) The department shall assure that an external quality review of each contracting HMO is performed that results in an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the HMO or its contractors furnish to Medicaid beneficiaries.

(2) The department shall provide a copy of the analysis of the Medicaid HMO annual audited health employer data and information set reports and the annual external quality review report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director, within 30 days of the department's receipt of the final reports from the contractors.

(3) The department shall work with the Michigan association of health plans and the Michigan association for local public health to improve service delivery and coordination in the MSS/ISS and EPSDT programs.

(4) The department shall assure that training and technical assistance are available for EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

Inclusion of mothers in Medicaid eligibility file and enrollment in health plan; time period.

Sec. 1666. To increase timely repayment of the maternity case rate to health plans and reduce the need to recover revenue from hospitals, the department shall implement system changes to assure that children who are born to mothers who are Medicaid eligible and enrolled in health plans are within 30 days after birth included in the Medicaid eligibility file and enrolled in the same health plan as the mother or any other health plan designated by the mother.

MIChild program; eligibility.

Sec. 1670. (1) The appropriation in part 1 for the MIChild program is to be used to provide comprehensive health care to all children under age 19 who reside in families with income at or below 200% of the federal poverty level, who are uninsured and have not had coverage by other comprehensive health insurance within 6 months of making application for MIChild benefits, and who are residents of this state. The department shall develop detailed eligibility criteria through the medical services administration public concurrence process, consistent with the provisions of this act. Health coverage for children in families between 150% and 200% of the federal poverty level shall be provided through a state-based private health care program.

(2) The department may provide up to 1 year of continuous eligibility to children eligible for the MIChild program unless the family fails to pay the monthly premium, a child reaches age 19, or the status of the children's family changes and its members no longer meet the eligibility criteria as specified in the federally approved MIChild state plan.

(3) Children whose category of eligibility changes between the Medicaid and MIChild programs shall be assured of keeping their current health care providers through the current prescribed course of treatment for up to 1 year, subject to periodic reviews by the department if the beneficiary has a serious medical condition and is undergoing active treatment for that condition.

(4) To be eligible for the MIChild program, a child must be residing in a family with an adjusted gross income of less than or equal to 200% of the federal poverty level. The department's verification policy shall be used to determine eligibility.

(5) The department shall enter into a contract to obtain MIChild services from any HMO, dental care corporation, or any other entity that offers to provide the managed health care benefits for MIChild services at the MIChild capitated rate. As used in this subsection:

(a) "Dental care corporation", "health care corporation", "insurer", and "prudent purchaser agreement" mean those terms as defined in section 2 of the prudent purchaser act, 1984 PA 233, MCL 550.52.

(b) "Entity" means a health care corporation or insurer operating in accordance with a prudent purchaser agreement.

(6) The department may enter into contracts to obtain certain MIChild services from community mental health service programs.

(7) The department may make payments on behalf of children enrolled in the MIChild program from the line-item appropriation associated with the program as described in the MIChild state plan approved by the United States department of health and human services, or from other medical services.

MIChild program; marketing and outreach.

Sec. 1671. From the funds appropriated in part 1, the department shall continue a comprehensive approach to the marketing and outreach of the MIChild program. The marketing and outreach required under this section shall be coordinated with current outreach, information dissemination, and marketing efforts and activities conducted by the department.

MIChild; establishment of premiums.

Sec. 1673. The department may establish premiums for MIChild eligible persons in families with income above 150% of the federal poverty level. The monthly premiums shall not be less than $10.00 or exceed $15.00 for a family.

MIChild program; available benefits; medically necessary services.

Sec. 1677. The MIChild program shall provide all benefits available under the state employee insurance plan that are delivered through contracted providers and consistent with federal law, including, but not limited to, the following medically necessary services:

(a) Inpatient mental health services, other than substance abuse treatment services, including services furnished in a state-operated mental hospital and residential or other 24-hour therapeutically planned structured services.

(b) Outpatient mental health services, other than substance abuse services, including services furnished in a state-operated mental hospital and community-based services.

(c) Durable medical equipment and prosthetic and orthotic devices.

(d) Dental services as outlined in the approved MIChild state plan.

(e) Substance abuse treatment services that may include inpatient, outpatient, and residential substance abuse treatment services.

(f) Care management services for mental health diagnoses.

(g) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(h) Emergency ambulance services.

Enhanced wages and new or enhanced employee benefits; continuation.

Sec. 1680. Payment increases for enhanced wages and new or enhanced employee benefits provided in previous years through the Medicaid nursing home wage pass-through program shall be continued.

Home- and community-based services; payment of family members, friends, and neighbors.

Sec. 1681. From the funds appropriated in part 1 for home- and community-based services, the department and local waiver agents shall encourage the use of family members, friends, and neighbors of home- and community-based services participants, where appropriate, to provide homemaker services, meal preparation, transportation, chore services, and other nonmedical covered services to participants in the Medicaid home- and community-based services program. This section shall not be construed as allowing for the payment of family members, friends, or neighbors for these services unless explicitly provided for in federal or state law.

Enforcement actions.

Sec. 1682. (1) The department shall implement enforcement actions as specified in the nursing facility enforcement provisions of section 1919 of title XIX, 42 USC 1396r.

(2) The department is authorized to receive and spend penalty money received as the result of noncompliance with medical services certification regulations. Penalty money, characterized as private funds, received by the department shall increase authorizations and allotments in the long-term care accounts.

(3) The department is authorized to provide civil monetary penalty funds to the disability network of Michigan to be distributed to the 15 centers for independent living for the purpose of assisting individuals with disabilities who reside in nursing homes to return to their own homes.

(4) The department is authorized to use civil monetary penalty funds to conduct a survey evaluating consumer satisfaction and the quality of care at nursing homes. Factors can include, but are not limited to, the level of satisfaction of nursing home residents, their families, and employees. The department may use an independent contractor to conduct the survey.

(5) Any unexpended penalty money, at the end of the year, shall carry forward to the following year.

Terminally ill and chronically ill individuals; preservation of dignity and rights; priority.

Sec. 1683. The department shall promote activities that preserve the dignity and rights of terminally ill and chronically ill individuals. Priority shall be given to programs, such as hospice, that focus on individual dignity and quality of care provided persons with terminal illness and programs serving persons with chronic illnesses that reduce the rate of suicide through the advancement of the knowledge and use of improved, appropriate pain management for these persons; and initiatives that train health care practitioners and faculty in managing pain, providing palliative care, and suicide prevention.

Medicaid home- and community-based services waiver program; administrative expenses; savings.

Sec. 1684. (1) Of the funds appropriated in part 1 for the Medicaid home- and community-based services waiver program, the payment rate allocated for administrative expenses for fiscal year 2007-2008 shall continue at the rate implemented in fiscal year 2005-2006 after the $2.00 per person per day mandated reduction.

(2) The savings realized from continuing the reduced administrative rate shall be reallocated to increase enrollment in the waiver program and to provide direct services to eligible program participants.

Nursing home rates.

Sec. 1685. All nursing home rates, class I and class III, must have their respective fiscal year rate set 30 days prior to the beginning of their rate year. Rates may take into account

the most recent cost report prepared and certified by the preparer, provider corporate owner or representative as being true and accurate, and filed timely, within 5 months of the fiscal year end in accordance with Medicaid policy. If the audited version of the last report is available, it shall be used. Any rate factors based on the filed cost report may be retroactively adjusted upon completion of the audit of that cost report.

Report; "single point of entry" defined.

Sec. 1686. (1) The department shall submit a report by April 30, 2008 to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the progress of 4 Medicaid long-term care single point of entry services pilot projects. The department shall also submit a final plan to the house of representatives and senate subcommittees on community health and the house and senate fiscal agencies 60 days prior to any expansion of the program.

(2) In addition to the report required under subsection (1), the department shall report all of the following to the house of representatives and senate appropriations subcommittees on community health and the house of representatives and senate fiscal agencies by September 30, 2008:

(a) The total cost of the single point of entry program.

(b) The total cost of each designated single point of entry.

(c) The total amount of Medicaid dollars saved because of the program.

(d) The total number of emergent single point of entry cases handled and the average length of time for placement in long-term care for those cases.

(e) The total number of single point of entry cases involving transfer from hospital settings to long-term care settings and the average length of time for placement of those cases in long-term care settings.

(3) It is the intent of the legislature that funding for the single point of entry for long-term care ends on September 30, 2009.

(4) As used in this section, "single point of entry" means a system that enables consumers to access Medicaid long-term care services and supports through 1 agency or organization and that promotes consumer education and choice of long-term care options.

Medicaid home- and community-based services waiver program for elderly and disabled; reimbursements to service providers providing personal care.

Sec. 1688. The department shall not impose a limit on per unit reimbursements to service providers that provide personal care or other services under the Medicaid home- and community-based services waiver program for the elderly and disabled. The department's per day per client reimbursement cap calculated in the aggregate for all services provided under the Medicaid home- and community-based services waiver is not a violation of this section.

Moving individuals from nursing homes to home- and community-based services waiver program.

Sec. 1689. (1) Priority in enrolling additional persons in the Medicaid home- and community-based services waiver program shall be given to those who are currently residing in nursing homes or who are eligible to be admitted to a nursing home if they are not provided home- and community-based services. The department shall use screening and assessment procedures to assure that no additional Medicaid eligible persons are admitted to nursing homes who would be more appropriately served by the Medicaid home- and community-based services waiver program.

(2) Within 30 days of the end of each fiscal quarter, the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies that details existing and future allocations for the home- and community-based services waiver program by regions as well as the associated expenditures. The report shall include information regarding the net cost savings from moving individuals from a nursing home to the home- and community-based services waiver program, the number of individuals transitioned from nursing homes to the home- and community-based services waiver program, the number of individuals on waiting lists by region for the program, and the amount of funds transferred during the fiscal quarter. The report shall also include the number of Medicaid individuals served and the number of days of care for the home- and community-based services waiver program and in nursing homes.

(3) The department shall develop a system to collect and analyze information regarding individuals on the home- and community-based services waiver waiting list to identify the community supports they receive, including, but not limited to, adult home help, food stamps, and housing assistance services and to determine the extent to which these community supports help individuals remain in their home and avoid entry into a nursing home. The department shall provide a progress report on implementation to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by June 1, 2008.

Adult home help workers; funding increase; conditions.

Sec. 1691. The funding increase provided in fiscal year 2006-2007 for the adult home help program shall be passed through to adult home help workers subject to the following conditions:

(a) Adult home help workers providing care under the adult home help program shall receive a wage of at least $7.50 per hour in all counties, effective April 1, 2008.

(b) The department, in conjunction with the department of human services, shall revise any policies, rules, procedures, or regulations that may be an administrative barrier to the implementation of the wage adjustments described in this section.

Federal Medicaid program; reimbursement for eligible services provided in Michigan schools.

Sec. 1692. (1) The department of community health is authorized to pursue reimbursement for eligible services provided in Michigan schools from the federal Medicaid program. The department and the state budget director are authorized to negotiate and enter into agreements, together with the department of education, with local and intermediate school districts regarding the sharing of federal Medicaid services funds received for these services. The department is authorized to receive and disburse funds to participating school districts pursuant to such agreements and state and federal law.

(2) From the funds appropriated in part 1 for medical services school services payments, the department is authorized to do all of the following:

(a) Finance activities within the medical services administration related to this project.

(b) Reimburse participating school districts pursuant to the fund-sharing ratios negotiated in the state-local agreements authorized in subsection (1).

(c) Offset general fund costs associated with the medical services program.

Special Medicaid reimbursement appropriation; increase; submission of medical services state plan amendment.

Sec. 1693. The special Medicaid reimbursement appropriation in part 1 may be increased if the department submits a medical services state plan amendment pertaining to this line

item at a level higher than the appropriation. The department is authorized to appropriately adjust financing sources in accordance with the increased appropriation.

Children's hospitals having high indigent care volume; distribution.

Sec. 1694. The department of community health shall distribute $695,000.00 to children's hospitals that have a high indigent care volume. The amount to be distributed to any given hospital shall be based on a formula determined by the department of community health.

Case mix reimbursement system for nursing facilities; progress report.

Sec. 1695. (1) The department shall evaluate the impact of implementing a case mix reimbursement system for nursing facilities. The department shall consult with representatives from the department, the health care association of Michigan, the Michigan county medical care facilities council, and the Michigan association of homes and services for the aging.

(2) The department shall provide a progress report to the senate and house appropriations subcommittees on community health and to the senate and house fiscal agencies by August 1, 2008.

Federal Medicaid or children health insurance program funds; use of funds as state match; use of funds to support new school-based or school-linked health services.

Sec. 1697. (1) As may be allowed by federal law or regulation, the department may use funds provided by a local or intermediate school district, which have been obtained from a qualifying health system, as the state match required for receiving federal Medicaid or children health insurance program funds. Any such funds received shall be used only to support new school-based or school-linked health services.

(2) A qualifying health system is defined as any health care entity licensed to provide health care services in the state of Michigan, that has entered into a contractual relationship with a local or intermediate school district to provide or manage school-based or school-linked health services.

Hospitals serving disproportionate share of indigent patients.

Sec. 1699. The department may make separate payments directly to qualifying hospitals serving a disproportionate share of indigent patients in the amount of $50,000,000.00, and to hospitals providing graduate medical education training programs. If direct payment for GME and DSH is made to qualifying hospitals for services to Medicaid clients, hospitals will not include GME costs or DSH payments in their contracts with HMOs.

MIChoice home- and community-based services waiver program screening process.

Sec. 1710. Any proposed changes by the department to the MIChoice home- and community-based services waiver program screening process shall be provided to the members of the house and senate appropriations subcommittees on community health 30 days prior to implementation of the proposed changes.

Medicaid emergency physicians professional services; maintenance of 2-tier reimbursement methodology; development of utilization adjustor.

Sec. 1711. (1) The department shall maintain the 2-tier reimbursement methodology for Medicaid emergency physicians professional services that was in effect on September 30, 2002, subject to the following conditions:

(a) Payments by case and in the aggregate shall not exceed 70% of Medicare payment rates.

(b) Total expenditures for these services shall not exceed the level of total payments made during fiscal year 2001-2002, after adjusting for Medicare copayments and deductibles and for changes in utilization.

(2) To ensure that total expenditures stay within the spending constraints of subsection (1)(b), the department shall develop a utilization adjustor for the basic 2-tier payment methodology. The adjustor shall be based on a good faith estimate by the department as to what the expected utilization of emergency room services will be during fiscal year 2007-2008, given changes in the number and category of Medicaid recipients. If expenditure and utilization data indicate that the amount and/or type of emergency physician professional services are exceeding the department's estimate, the utilization adjustor shall be applied to the 2-tier reimbursement methodology in such a manner as to reduce aggregate expenditures to the fiscal year 2001-2002 adjusted expenditure target.

Rural health initiative.

Sec. 1712. (1) Subject to the availability of funds, the department shall implement a rural health initiative. Available funds shall first be allocated as an outpatient adjustor payment to be paid directly to hospitals in rural counties in proportion to each hospital's Medicaid and indigent patient population. Additional funds, if available, shall be allocated for defibrillator grants, EMT training and support, or other similar programs.

(2) Except as otherwise specified in this section, "rural" means a county, city, village, or township with a population of not more than 30,000, including those entities if located within a metropolitan statistical area.

Medicaid adult benefits waiver program; constant enrollment level.

Sec. 1716. The department shall seek to maintain a constant enrollment level within the Medicaid adult benefits waiver program throughout fiscal year 2007-2008.

Disproportionate share hospital funding; creation of 2 pools for distribution; report.

Sec. 1717. (1) The department shall create 2 pools for distribution of disproportionate share hospital funding. The first pool, totaling $45,000,000.00, shall be distributed using the distribution methodology used in fiscal year 2003-2004. The second pool, totaling $5,000,000.00, shall be distributed to nonpublic unaffiliated hospitals and hospital systems that received less than $900,000.00 in disproportionate share hospital payments in fiscal year 2003-2004 based on a formula that is weighted proportional to the product of each eligible system's Medicaid revenue and each eligible system's Medicaid utilization, except that no payment of less than $1,000.00 shall be made.

(2) By September 30, 2008, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the new distribution of funding to each eligible hospital from the 2 pools.

Denial of home help services; hearing.

Sec. 1718. The department shall provide each Medicaid adult home help beneficiary or applicant with the right to a fair hearing when the department or its agent reduces, suspends, terminates, or denies adult home help services. If the department takes action to reduce, suspend, terminate, or deny adult home help services, it shall provide the beneficiary or applicant with a written notice that states what action the department proposes to take, the reasons for the intended action, the specific regulations that support the action, and an explanation of the beneficiary's or applicant's right to an evidentiary hearing and the circumstances under which those services will be continued if a hearing is requested.

Medicare recovery program.

Sec. 1720. The department shall continue its Medicare recovery program.

Prepayment of funds to nursing home or other health care facility; return of funds to individual; report.

Sec. 1721. The department shall conduct a review of Medicaid eligibility pertaining to funds prepaid to a nursing home or other health care facility that are subsequently returned to an individual who becomes Medicaid eligible and shall report its findings to the members of the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies not later than May 15, 2008. Included in its report shall be recommendations for policy and procedure changes regarding whether any funds prepaid to a nursing home or other health care facility that are subsequently returned to an individual, after the date of Medicaid eligibility and patient pay amount determination, shall be considered as a countable asset and recommendations for a mechanism for departmental monitoring of those funds.

Health services provided by Hutzel hospital; payment.

Sec. 1722. (1) From the funds appropriated in part 1 for special Medicaid reimbursement payments, the department is authorized to make a disproportionate share payment of $33,167,700.00 for health services provided by Hutzel Hospital.

(2) The funding authorized under subsection (1) shall only be expended if the necessary Medicaid matching funds are provided by, or on behalf of, the hospital as allowable state match.

Dispensing of injectable drugs by pharmacies to physicians' offices.

Sec. 1724. The department shall allow licensed pharmacies to purchase injectable drugs for the treatment of respiratory syncytial virus for shipment to physicians' offices to be administered to specific patients. If the affected patients are Medicaid eligible, the department shall reimburse pharmacies for the dispensing of the injectable drugs and reimburse physicians for the administration of the injectable drugs.

Reduction of Medicaid eligibility errors.

Sec. 1725. The department shall continue to work with the department of human services to reduce Medicaid eligibility errors related to basic eligibility requirements and income requirements.

Freestanding electrical lifting and transferring devices; availability.

Sec. 1728. The department shall make available to qualifying Medicaid recipients, not based on Medicare guidelines, freestanding electrical lifting and transferring devices.

Asset test; determination of Medicaid eligibility.

Sec. 1731. (1) Subject to subsection (2), the department shall continue an asset test to determine Medicaid eligibility for individuals who are parents, caretaker relatives, or individuals between the ages of 18 and 21 and who are not required to be covered under federal Medicaid requirements.

(2) Pending federal approval, regardless of the results of the asset test established under subsection (1), an individual who is between the ages of 18 and 21 and is not required to be covered under the federal Medicaid requirements is not eligible for the state Medicaid program if his or her parent, parents, or legal guardian has health care coverage for him or her or has access to health care coverage for him or her.

Reductions in nursing home reimbursement rates prohibited; conditions.

Sec. 1732. The department shall assure that, if proposed modifications to the quality assurance assessment program for nursing homes are not implemented, the projected general fund/general purpose savings shall not be achieved through reductions in nursing home reimbursement rates.

Electronic prescribing and other technology initiatives.

Sec. 1733. The department shall seek additional federal funds to permit the state to provide financial support for electronic prescribing and other health information technology initiatives.

Positive health behavior; financial incentives.

Sec. 1734. The department shall seek federal funds that will permit the state to provide financial incentives for positive health behavior practiced by Medicaid recipients. The structure of this incentive program may be similar to programs in other states that authorize monetary rewards to be deposited in individual accounts for Medicaid recipients who demonstrate positive changes in health behavior.

Preferred provider program or alternative program for durable medical equipment; creation; establishment of committee.

Sec. 1735. (1) The department shall establish a committee that will attempt to identify possible Medicaid program savings associated with the creation of a preferred provider program or an alternative program for durable medical equipment.

(2) To assure quality and access, the preferred provider program shall involve providers who can offer a broad statewide network of services and who are accredited by the joint commission on accreditation of health care organizations or the accreditation commission for health care, inc.

(3) This committee shall include, at minimum, representatives from each of the contracted Medicaid HMOs, the medical services administration, the Michigan state medical society, the Michigan osteopathic society, the Michigan home health association, the Michigan health and hospital association, and 2 accredited providers.

(4) By October 1, 2007, the department shall report to the senate and house of representatives subcommittees on community health and the state budget director on possible durable medical equipment contracting opportunities and anticipated Medicaid program savings.

(5) The department shall provide a copy of any proposed Medicaid policy changes for durable medical equipment to the house of representatives and senate subcommittees on community health, the senate and house fiscal agencies, and the state budget director at least 30 days prior to implementation.

Medical outcome targets for most prevalent and costly ailments affecting Medicaid recipients.

Sec. 1739. The department shall continue to establish medical outcome targets for the 10 most prevalent and costly ailments affecting Medicaid recipients. The department may use indicators that recipients are successfully managing chronic disease, measures of recipient compliance with treatment plans, and studies of the proportion of Medicaid providers who follow established best practices in treating chronic disease as possible medical outcome target measures. The department shall make bonus payments, independent of HMO rate adjustments utilized in fiscal year 2005-2006, available to Medicaid HMOs that meet these outcome targets.

Distribution of GME funds.

Sec. 1740. From the funds appropriated in part 1 for health plan services, the department shall assure that all GME funds are promptly distributed to qualifying hospitals using a methodology developed in consultation with the graduate medical education advisory group. The advisory group shall include representatives of the Michigan health and hospital association and Michigan association of health plans.

Nursing homes; receipt of interim payments.

Sec. 1741. The department shall continue to provide nursing homes the opportunity to receive interim payments upon their request. The department shall make efforts to ensure that the interim payments are as similar to expected cost-settled payments as possible.

Retention of amount in special Medicaid reimbursement funding by public hospital; conditions.

Sec. 1742. The department shall allow the retention of $1,000,000.00 in special Medicaid reimbursement funding by any public hospital that meets each of the following criteria:

(a) The hospital participates in the intergovernmental transfers.

(b) The hospital is not affiliated with a university.

(c) The hospital provides surgical services.

(d) The hospital has at least 10,000 Medicaid bed days.

Matching adult home help providers with service recipients.

Sec. 1747. In order to be reimbursed for adult home help services provided to Medicaid recipients, the matching of adult home help providers with service recipients shall be coordinated by the local county department of human services.

Use of standard billing formats.

Sec. 1749. Effective September 30, 2007, the department shall require all Medicaid health plans to use the same standard billing formats.

Determination of party responsible for payment of health benefits.

Sec. 1752. The department shall provide a Medicaid health plan with any information that may assist the Medicaid health plan in determining whether another party may be responsible, in whole or in part, for the payment of health benefits.

Specialized case and care management program.

Sec. 1756. The department shall establish and implement a specialized case and care management program to serve the most costly Medicaid beneficiaries who are not enrolled in a health plan and are noncompliant with medical management, including persons with chronic diseases and mental health diagnoses, high prescription drug utilizers, members demonstrating noncompliance with previous medical management, and neonates. The case and care management program shall, at a minimum, provide a performance payment incentive for physicians who manage the recipient's care and health costs in the most effective way. The department may also develop additional contractual arrangements with 1 or more Medicaid HMOs for the provision of specialized case management services. Contracts with Medicaid HMOs may include provisions requiring collection of data related to Medicaid recipient compliance. Measures of patient compliance may include the proportion of clients who fill their prescriptions, the rate of clients who do not show for scheduled medical appointments, and the proportion of clients who use their medication.

Proof that Medicaid recipients are United States citizens or legal residents.

Sec. 1757. The department shall direct the department of human services to obtain proof from all Medicaid recipients that they are legal United States citizens or otherwise legally residing in this country before approving Medicaid eligibility.

Number of individuals receiving emergency services only Medicaid benefit; report.

Sec. 1758. The department shall submit a report on the number of individuals who receive the emergency services only Medicaid benefit and the annual amount of Medicaid expenditures for this population to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies by April 1, 2008.

Federal deficit reduction act of 2005; policy changes.

Sec. 1759. The department shall implement the following policy changes included in the federal deficit reduction act of 2005, Public Law 109-171:

(a) Lengthening the look back policy for asset transfers from 3 to 5 years.

(b) Changing the penalty period to begin the day an individual applies for Medicaid.

(c) Individuals with more than $500,000.00 in home equity do not qualify for Medicaid.

(d) Utilize the Medicaid false claim act, 1977 PA 72, MCL 400.601 to 400.613, to collect an enhanced state share of damages collected from entities that have been successfully prosecuted for filing a fraudulent Medicaid claim.

Recovery of funds by medical services administration; distribution.

Sec. 1761. (1) The department shall distribute all funds recovered by the medical services administration from prior and future Medicaid access to care initiative payments exceeding the hospital upper payment limit for inpatient and outpatient services to a hospital that meets any of the following characteristics:

(a) Is located in a rural county as determined by the most recent United States census or is located in a city or a village or township with a population of not more than 12,000 in a county with a population with not more than 70,000 as of the official federal 2000 decennial census.

(b) Is a Medicare sole community hospital.

(c) Is a Medicare dependent hospital and rural referral center hospital.

(2) The distribution under subsection (1) shall be based upon each hospital's Medicaid fee-for-service and HMO payments as developed in consultation with rural hospitals and the Michigan health and hospital association.

Pilot project; health information exchange infrastructure.

Sec. 1763. From the funds appropriated in part 1 for health plan services, Medicaid health plans in southeast Michigan shall participate in a risk adverse, budget-neutral 10-month production pilot with a Michigan-based service provider when an interoperable hub that provides secure aggregation and access to medication history data through the use of an existing, outsourced health information exchange infrastructure has been developed. The infrastructure will provide cross domain single sign-on allowing for realtime, data aggregation across disparate organizations and systems. The pilot project shall include a methodology to identify and measure savings generated by the pilot project. Medicaid health plan payments for the project shall not exceed the savings achieved.

Certification of rates.

Sec. 1764. The department shall annually certify rates paid to Medicaid health plans as being actuarially sound in accordance with federal requirements and shall provide a copy of the rate certification and approval immediately to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies.

Payment of pharmacists for prescriptions; impact of change in payment; report.

Sec. 1767. The department shall study and evaluate the impact of the change in the way in which the Medicaid program pays pharmacists for prescriptions from average wholesale price to average manufacturer price as required by the federal deficit reduction act of 2005, Public Law 109-171. By March 1, 2008, the department shall submit a report of its study to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies. If the department finds that there is a negative impact on the pharmacists, the department shall reexamine the current pharmaceutical dispensing fee structure established under section 1620 and include in the report recommendations and proposals to counter the negative impact of that federal legislation.

Proposed Medicaid policy bulletin or adjustment to Medicaid provider manual; effective date.

Sec. 1770. In conjunction with the consultation requirements of the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, and except as otherwise provided in this section, the department shall attempt to make the effective date for a proposed Medicaid policy bulletin or adjustment to the Medicaid provider manual on October 1, January 1, April 1, or July 1 after the end of the consultation period. The department may provide an effective date for a proposed Medicaid policy bulletin or adjustment to the Medicaid provider manual other than provided for in this section if necessary to be in compliance with federal or state law, regulations, or rules or with an executive order of the governor.

Enrollment of foster care children in Medicaid health maintenance organization.

Sec. 1772. From the funds appropriated in part 1, the department shall establish a program on or before July 1, 2008, the primary goal of which is to enroll all children in foster care in Michigan in a Medicaid health maintenance organization.

Medicaid covered nonemergency transportation services; bid process.

Sec. 1773. The department shall establish and implement a bid process to identify a single private contractor to provide Medicaid covered nonemergency transportation services in each county with a population over 750,000 individuals.

Report.

Sec. 1774. The department shall provide the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by March 1, 2008 a report that details all of the following:

(a) Expenditure of money follows the person funds to date.

(b) Estimated general fund savings generated through use of money follows the person.

(c) Total number of individuals receiving services through the money follows the person grant.

Delivery of Medicaid long-term care services; use of managed care; study.

Sec. 1775. (1) The department shall study the feasibility of using managed care to deliver Medicaid long-term care services. The study shall focus upon the following:

(a) If there is a sufficient number of organizations interested in providing these services.

(b) The extent of services provided through Medicaid managed long-term care.

(c) Estimated changes in Medicaid long-term care expenditure associated with implementing managed care for these services.

(2) The department shall report the results of this study to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by June 1, 2008.

Medicaid reduction factor; use by department.

Sec. 1776. If the department continues to utilize the Medicare outpatient prospective payment system methodology to reimburse hospitals for Medicaid clients seen in the outpatient setting including the emergency room, then the Medicaid reduction factor utilized by the department to compute the amount of payment made by Medicaid health plans to hospitals must be revenue neutral and actuarially sound.

Use of dining assistants.

Sec. 1777. From the funds appropriated in part 1 for long-term care services, the department shall permit, in accordance with applicable federal and state law, nursing homes to use dining assistants to feed eligible residents if legislation to permit the use of dining assistants is enacted into law. The department shall not be responsible for costs associated with training dining assistants.

Small and rural hospitals and hospital facilities with neonatal intensive care units and pediatric intensive care units; allocation.

Sec. 1778. The department, in cooperation with the Michigan health and hospital association, shall implement a disproportionate share hospital payment that allocates a total of $50,000,000.00 to small and rural hospitals and a total of $10,000,000.00 to hospital facilities with neonatal intensive care units and pediatric intensive care units. The department shall share the payment methodology with the state budget director, members of the house and senate appropriations subcommittees on community health, and the house and senate fiscal agencies 30 days prior to submission of the plan to the federal government.

Physician primary care codes fee screens and hospital neonatal and pediatric intensive care unit payments; funding.

Sec. 1780. If congressional action results in an increase in Michigan's federal medical assistance percentage in fiscal year 2008, it is the intent of the legislature that a portion of this new funding be used to augment physician primary care codes fee screens and hospital neonatal and pediatric intensive care unit payments.

Plan first program, long-term care programs, and other programs; pilot project to demonstrate effectiveness.

Sec. 1781. The department may conduct a pilot project to demonstrate improvements in the efficiency and effectiveness of the plan first program, long-term care programs, and other programs as identified by the department. In conducting the pilot project, the department shall consult with other affected programs and agencies. In conducting the pilot, the department or its designee shall have direct access to the department of human services eligibility, budget, and registration systems for purposes of initial processing, including taking applications, assisting applicants in completing the application, providing information

and referrals, obtaining required documentation to complete processing of the application, and assuring the information contained on the application form is complete. To the extent practical and desirable, trusted third-party data sources may be accessed to verify income and asset information during the financial eligibility determination process. The department shall issue a report to the legislature summarizing the results of the pilot project and recommendations for the future.

This act is ordered to take immediate effect.
Approved October 31, 2007.
Filed with Secretary of State October 31, 2007.

[No. 124]

(HB 4348)

AN ACT to make appropriations for the department of corrections and certain state purposes related to corrections for the fiscal year ending September 30, 2008; to provide for the expenditure of the appropriations; to provide for reports; to provide for the creation of certain advisory committees and boards; to prescribe certain powers and duties of the department of corrections, certain other state officers and agencies, and certain advisory committees and boards; to provide for the collection of certain funds; and to provide for the disposition of fees and other income received by certain state agencies.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS

Appropriations; department of corrections.

Sec. 101. Subject to the conditions set forth in this act, the amounts listed in this part are appropriated for the department of corrections for the fiscal year ending September 30, 2008, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF CORRECTIONS

APPROPRIATION SUMMARY:		
Average population	51,841	
Full-time equated unclassified positions	16.0	
Full-time equated classified positions	17,637.4	
GROSS APPROPRIATION		$ 2,078,269,100
Appropriated from:		
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		1,264,600
ADJUSTED GROSS APPROPRIATION		$ 2,077,004,500
Federal revenues:		
Total federal revenues		10,340,700
Special revenue funds:		
Total local revenues		429,700
Total private revenues		0
Total other state restricted revenues		70,149,600
State general fund/general purpose		$ 1,996,084,500