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

(3) The department shall develop a feasibility study on a payment methodology that increases allotments to coordinating agencies that are also community mental health providers. The department shall report on this feasibility study on a payment methodology to the senate and house subcommittees on community health and the senate and house fiscal agencies by April 1 of the current fiscal year.

Substance abuse prevention, education, and treatment programs; data; report.

Sec. 408. (1) By April 15 of the current fiscal year, the department shall report the following data from fiscal year 2007-2008 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.

Providers furnishing child care services; priority.

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 as requirement for public assistance.

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.

Jail diversion services.

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 2007-2008.

Medicaid substance abuse treatment services; managed care plan; implementation.

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; report on amount of funding paid to PIHPs.

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 the preceding 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; establishment of 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 of the current fiscal year.

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, shall 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.

Increase in PIHP capitation rates; local funds as part of state match requirement.

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.

Payment of matching funds by county; equal 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 of the current fiscal year.

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.

Policy leading to negative financial impact on CMHSPs or PIHPs; retroactive implementation prohibited.

Sec. 452. Unless otherwise authorized by law, the department shall not implement retroactively any policy that would lead to a negative financial impact on CMHSPs or PIHPs.

Mental illness, developmental disabilities, or substance abuse issues; consumer choice; placement in least restrictive setting.

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.

Reports.

Sec. 458. By April 15 of the current fiscal year, 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 each of the 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.

Mental health courts; pilot programs.

Sec. 459. From the funds appropriated in part 1 for mental health court pilot programs, the department shall work with the judiciary, including the state court administrative office, to develop guidelines for the operation and evaluation of pilot mental health courts. Local CMHSPs and trial courts interested in becoming mental health court pilot sites shall submit a joint application for funding prepared in accordance with guidelines established by the department and judiciary. The applications shall include documentation of community needs and a commitment to the program by key stakeholders, including the local courts, law enforcement, prosecutor, defense counsel, and treatment providers.

Administrative costs; implementation of definitions, standards, and instructions; progress report.

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 that were implemented in fiscal year 2006-2007 by the department shall also be implemented for their subcontractors in fiscal year 2008-2009.

(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 of the current fiscal year.

Funding equity plan.

Sec. 462. The department shall develop 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 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 and a report regarding implementation feasibility of the equity funding plan including an impact statement to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director by March 1 of the current fiscal year.

Programs to reduce and prevent substance abuse; evaluation measures to assess 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 received 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.

Children with emotional disturbances; respite care services for children and families.

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.

Substance abuse coordinating agencies; funding.

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.

City, county, or regional substance abuse coordinating agency; criteria for incorporating into local community mental health authority.

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 maintain 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 maintenance of the criteria under 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.

Coordinating agencies that have incorporated into community mental health authorities; written expectations.

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, 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 of the current fiscal year, 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; providing information.

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.

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 of the current fiscal year a report on the number and reimbursement cost of atypical antipsychotic prescriptions by each PIHP for Medicaid beneficiaries.

Odyssey house; funding for programs.

Sec. 482. From the funds appropriated in part 1, the department shall continue funding for programs provided by Odyssey house at the levels in effect during fiscal year 2007-2008.

Eligibility of incarcerated Medicaid recipient; limitation on coverage.

Sec. 483. (1) A Medicaid recipient shall remain eligible and a qualifying applicant shall be determined eligible for medical assistance during a period of incarceration or detention. Medicaid coverage is limited during such a period to off-site inpatient hospitalization only.

(2) A Medicaid recipient is considered incarcerated or detained until released on bail, released as not guilty, released on parole, released on probation, released on pardon, released upon completing a sentence, or released under home detention or tether.

Mental health prevention initiatives.

Sec. 486. From the funds appropriated in part 1, up to $100.00 may be allocated for mental health prevention initiatives.

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

Obtaining third-party payments for services; revenues collected through recapture projects.

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.

Gifts and bequests for patient living and treatment environments.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $1,000,000.00 remaining on September 30 of the current fiscal year 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.

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.

Report; information to be provided.

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 and 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.

Placement in state hospitals and centers; patient reimbursement from first- and third-party payers.

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.

Changes in operation of state hospitals and centers; support from department; condition.

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.

State hospitals and centers; privatization of food and custodial services.

Sec. 608. By January 1 of the current fiscal year, 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.

Tobacco products; use prohibited.

Sec. 609. Effective October 1, 2008, the department shall ban the use of all tobacco products in and on the grounds of state psychiatric facilities. As used in this section, "tobacco product" means a product that contains tobacco and is intended for human consumption, including, but not limited to, cigarettes, noncigarette smoking tobacco, or smokeless tobacco, as those terms are defined in section 2 of the tobacco products tax act, 1993 PA 327, MCL 205.422, and cigars.

PUBLIC HEALTH ADMINISTRATION

Health consumption advisory for sportfish; availability.

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; status report on goals and objectives.

Sec. 651. By April 30 of the current fiscal year, 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

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.

Nursing home inspectors.

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

Nursing scholarship program.

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 patient care hours and percentage of pool staff used; quarterly staff 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.

Dentists; loan repayment program.

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; 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 that are similar to federally qualified health centers.

Nonconfidential information; availability.

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.

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 that provide primary care services; support.

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 and number of substantiated allegations; report.

Sec. 714. The department shall report to the legislature on the timeliness of nursing facility complaint investigations and the number of allegations that are substantiated on an annual basis. The report shall consist of the number of allegations 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.

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

Investigations; 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 the uninsured.

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

Most frequently cited complaint deficiencies.

Sec. 718. The department shall gather information on its most frequently cited complaint deficiencies for the prior 3 fiscal years. The department shall determine whether there is an increase in the number of citations from 1 year to the next and assess the cause of the increase, if any, and whether education and training of nursing facility staff or department staff is needed. The department will implement any training indicated by the study. The department shall provide the results of the study to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by May 1 of the current fiscal year.

Helen M. Nickless volunteer clinic in Bay City.

Sec. 720. From the funds appropriated in part 1 for primary care services, $75,000.00 shall be allocated to the Helen M. Nickless volunteer clinic in Bay City.

Michigan essential health provider program; loan repayments.

Sec. 722. A medical professional who is newly accepted into the Michigan essential health provider program in fiscal year 2008-2009 is eligible for 4 years of loan repayments.

Statewide trauma care system.

Sec. 724. From the funds appropriated in part 1 for emergency medical services program state staff, up to $100.00 may be allocated for the development of a coordinated statewide trauma care system.

Rural health improvement; availability of funds.

Sec. 725. From the funds appropriated in part 1 for rural health services, up to $100.00 may be allocated to support rural health improvement as identified in "Michigan Strategic Opportunities for Rural Health Improvement, A State Rural Health Plan 2008-2012". The department shall make these funds available to rural and micropolitan communities under a competitive bid process. The department shall not allocate more than $5,000.00 to each rural or micropolitan community under this section. The department shall not allocate funds appropriated under this section unless a 50/50 state and local match rate has occurred. The

department shall submit a report to the house and senate appropriations subcommittees on community health, house and senate fiscal agencies, and state budget director by April 1 of the current fiscal year on the projects supported by this allocation.

INFECTIOUS DISEASE CONTROL

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

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 receive priority for prevention, education, and outreach services.

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.

Prisoners who are released who are HIV positive or positive for hepatitis C antibody; sharing data and information.

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 of the current fiscal year, 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.

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.

Methamphetamine cleanup fund; availability.

Sec. 852. (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.

LOCAL HEALTH ADMINISTRATION AND GRANTS

Implementation of MCL 333.17015; reimbursement for costs.

Sec. 901. The amount appropriated in part 1 for implementation of the 1993 additions of or 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.

District health department participation with other local health departments; dissolution; 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, 2008, 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.

Local public health operations; allocations.

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 shall 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 2008-2009 of at least the amount expended in fiscal year 1992-1993 for the services described in subsection (1).

(4) By April 1 of the current fiscal year, 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.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Alzheimer's information network; 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; 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 management program in Muskegon County.

Sec. 1008. From the funds appropriated in part 1 for the diabetes and kidney program, the department may allocate up to $25,000.00 for a diabetes management pilot project in Muskegon County.

National Kidney Foundation of Michigan; allocation.

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.

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.

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.

Level I and level II trauma hospitals; establishment of incentive-based pilot programs.

Sec. 1031. (1) From the funds appropriated in part 1 for the injury control intervention project, $300,000.00 shall be used to establish 2 incentive-based pilot programs 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) One pilot program shall be placed in a county of less than 225,000. The other pilot program shall be placed in a county with a population over 1,000,000.

Predictive molecular therapeutics program; allocation to Van Andel Institute.

Sec. 1032. From the funds appropriated in part 1 for the cancer prevention and control program, up to $100.00 may be allocated to the Van Andel Institute for phase II of the predictive molecular therapeutics program for the late stage treatment of Medicaid eligible pediatric and adult cancer patients.

Kids kicking cancer program.

Sec. 1033. From the funds appropriated in part 1 for the cancer prevention and control program, up to $100.00 may be allocated to the kids kicking cancer program.

Cold is cool program.

Sec. 1034. From the funds appropriated in part 1 for physical fitness, nutrition, and health, up to $100.00 may be allocated to the Michigan snowsports industries association for the cold is cool program to expose Michigan schoolchildren to outdoor winter activities and downhill skiing.

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.

Local MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs; report; needs of rural communities.

Sec. 1104. (1) Before April 1 of the current fiscal year, 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 immediately preceding fiscal year.

(c) A breakdown of the expenditure of these funds between urban and rural communities.

(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 30,000 or less, including those entities if located within a metropolitan statistical area.

Evaluation of contracting 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 include the 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.

Sec. 1106. Each family planning program receiving federal title X family planning funds under 42 USC 300 to 300a-8 shall be in compliance with all performance and quality assurance indicators that the office of family planning within the United States department of health and human 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; expenditures.

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.

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 provides 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 from the immediately preceding fiscal year.

Agencies receiving pregnancy prevention 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 and be designated as delegate agencies.

Family planning/pregnancy prevention services; allocation.

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.

Prenatal care outreach and service delivery support.

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.

Statewide coordinated regional perinatal system; restoration.

Sec. 1116. The department shall convene appropriate stakeholders to determine the efficacy and impact of restoring a statewide coordinated regional perinatal system in Michigan. A report shall be produced that reflects best practices, expected potential impact on infant mortality, and recommendations for policy and funding of such a system in Michigan. The report shall be provided to the house and senate appropriations subcommittees on community health and standing committees on health policy, the house and senate fiscal agencies, and the state budget director by April 1, 2009.

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 to public health departments.

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.

Health education curriculum; Michigan model; examination of textbook or other classroom materials.

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 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.

Alzheimer's disease patient care training program.

Sec. 1137. From the funds appropriated in part 1 for special projects, up to $100.00 may be allocated to support an Alzheimer's disease patient care training program involving a community college and a retirement community.

WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Project FRESH.

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.

WIC programs; access to individuals in 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

Medical care and treatment of children with special health care needs; reimbursement policies; exceptions.

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. The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies the number of exceptions granted under this section.

Department; providing certain medical care and treatment; powers.

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.

Referral of eligible children 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 justice assistance grant program funding.

Sec. 1250. The department shall provide up to $1,800,000.00 in Byrne justice assistance 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 $200,000.00 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 emergency treatment of sexual assault victims.

Sec. 1304. The department shall work with the department of state police, the Michigan health and 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 waiting lists; criteria; report.

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 eligible home- and community-based services.

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; allocation of funds.

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.

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 office of services to the aging shall adjust allocations to area agencies on aging to account for any changes in county membership. The office of services to the aging 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 for frail elderly.

Sec. 1416. The legislature very 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 of the current fiscal year 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; approval of waiver.

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; participation of insurance entities; determination; 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; copy to be provided 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.

Elderly and disabled persons; medical services; income requirement.

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.

Buy-in of medical coverage; establishment of program.

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 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.

Medicaid covered services relating to pregnancy.

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.

(6) Effective October 1, 2008, the department shall mandate enrollment of women, whose qualifying condition is pregnancy, into Medicaid managed care plans.

(7) The department shall encourage physicians to provide women, whose qualifying condition for Medicaid is pregnancy, with a referral to a Medicaid participating dentist at the first pregnancy-related appointment.

Cost report grievances; review.

Sec. 1610. The department 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 recipients with other third-party payment sources; payment rate.

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.

Fee-for-service recipients not residing in nursing homes; pharmaceutical dispensing fee.

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) For fee-for-service recipients who do not reside in nursing homes, effective April 1 of the current fiscal year, the pharmaceutical dispensing fee shall be $2.75 or the pharmacy's usual or customary cash charge, whichever is less. For nursing home residents, effective April 1 of the current fiscal year, the pharmaceutical dispensing fee shall be $3.00 or the pharmacy's usual or customary cash charge, whichever is less.

(3) 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.

(4) 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, a pharmacist-approved medication therapy program, 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 osteopathic association, 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.

Atypical antipsychotic medications.

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

Outpatient drugs; quarterly rebates from pharmaceutical manufacturers.

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.

Generic drugs; 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; hearing aids; limitations.

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.

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; 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.

Medical services program; cost report.

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.

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.

Assignment to managed care provider; medical exceptions to HMO enrollment; criteria.

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; election.

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 part 418.

Expansion of services by Medicaid HMOs to counties.

Sec. 1652. Any new contracts with Medicaid health plans negotiated or signed, or both, during the current fiscal year shall include the following provisions regarding expansion of services by the Medicaid HMOs to counties not previously served by that Medicaid HMO:

(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 through HMOs; implementation and contracting.

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. Children's special health care services recipients shall be informed of the opportunity to enroll in HMOs.

(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.

(f) 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 regulation 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.

Services delivered through other than HMO's providers; 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.

Selection of HMO; lock-in period.

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; toll-free telephone number.

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 stabilization of Medicaid recipient in hospital emergency room; further medical service or hospitalization; 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) The department shall provide a report by September 30 of the current fiscal year 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.

Contracts with hospitals within reasonable distance of enrollees; 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.

Applicability of sections to certain 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, 1607, 1650, 1651, 1652, 1653, 1654, 1655, 1656, 1657, 1658, 1660, 1661, 1662, 1666, 1699, 1711, 1752, 1783, 1787, and 1791.

Access to 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 prohibit HMOs from requiring prior authorization of their contracted providers for any EPSDT screening and diagnosis services.

(4) The department shall require HMOs to be responsible for well child visits 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.

Access to 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 MSS/ISS screening referral, or for up to 3 MSS/ISS service visits.

(3) The department shall require HMOs to be responsible for 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.

(4) 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.

(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 pregnant women.

External quality review.

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 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.

(3) 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.

(4) 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.

(5) 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.

Enrollment of children in health plan within certain number of days after birth.

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 criteria; duration; change of category eligibility; verification policy; contract with HMO; definitions; payments; external quality review.

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.

(8) The department shall assure that an external quality review of each MIChild contractor, as described in subsection (5), is performed, which analyzes and evaluates the aggregated information on quality, timeliness, and access to health care services that the contractor furnished to MIChild beneficiaries.

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; benefits; requirements.

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.

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.

Use of family members, friends, and neighbors for certain services.

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.

Nursing facility enforcement provisions; implementation of 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.

Dignity and rights of terminally ill and chronically ill individuals.

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.

Waiver program; reduced administrative rate.

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 2008-2009 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.

Medicaid long-term care single point of entry services pilot projects.

Sec. 1686. (1) The department shall submit a report by April 30 of the current fiscal year 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 of the current fiscal year:

(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) 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.

Service providers providing personal care or other services; limit on per unit reimbursements prohibited.

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.

Enrolling persons into Medicaid home- and community-based services waiver program; priority; reports.

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 60 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 of the current fiscal year.

Quality assurance indicators; reports.

Sec. 1690. (1) The department shall submit a report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by April 1 of the current fiscal year, to include all data collected on the quality assurance indicators in the preceding fiscal year for the home- and community-based services waiver program, as well as quality improvement plans and data collected on critical incidents in the waiver program and their resolutions.

(2) The department shall submit a report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by April 1 of the current fiscal year, to include all data collected on the quality assurance indicators in the preceding fiscal year for the adult home help program, as well as quality improvement plans and data collected on critical incidents in the adult home help program and their resolutions.

Adult home help program; 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.

Services provided in Michigan schools; reimbursement from federal government; agreements.

Sec. 1692. (1) The department 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.

Distribution to children's hospitals having high indigent care volume.

Sec. 1694. The department 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.

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 of the current fiscal year.

Funds obtained by local or intermediate school system from qualifying health system; use as state matching funds; qualifying health system defined.

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.

GME costs or DSH payments.

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; proposed changes.

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; 2-tier reimbursement methodology; conditions; 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 2008-2009, 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; enrollment level.

Sec. 1716. The department shall seek to maintain a constant enrollment level within the Medicaid adult benefits waiver program throughout fiscal year 2008-2009.

Distribution of disproportionate share hospital funding; creation of 2 pools; 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 unaffiliated hospitals and hospital systems that received less than $900,000.00 in disproportionate share hospital payments in fiscal year 2007-2008 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 of the current fiscal year, 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.

Reduction, suspension, termination, or denial of adult 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.

Funds prepaid to health care facility that are returned to individual who becomes Medicaid eligible; review by department.

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 of the current fiscal year. 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; disproportionate share 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.

Treatment of respiratory syncytial virus; purchase of injectable drugs by pharmacies; shipment to physicians' offices; reimbursement to pharmacies and physicians.

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.

Medicaid eligibility errors; reduction.

Sec. 1725. The department shall continue to work with the department of human services and the department of state police to reduce Medicaid eligibility errors related to basic eligibility requirements, residency issues, felony status issues, 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.

Medicaid eligibility; asset test for certain individuals.

Sec. 1731. 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.

Quality assurance assessment program for nursing homes; modifications not implemented; reductions in nursing home reimbursement rates prohibited.

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 health information technology initiatives.

Sec. 1733. (1) The department shall seek additional federal funds to permit the state to provide financial support for electronic prescribing and other health information technology initiatives.

(2) The department shall develop a 3-year strategic plan for the implementation of electronic prescribing for the Medicaid program.

Positive health behavior; financial incentives.

Sec. 1734. The department shall seek federal money for demonstration programs that will permit this state to provide financial incentives for positive health behavior practiced by Medicaid recipients, including, but not limited to, consumer-driven strategies that enable Medicaid recipients to choose coverage that meets their individual needs and that authorize monetary or other rewards for demonstrating positive health behavior changes.

Medical outcome targets for 10 most prevalent and costly ailments; use of indicators; bonus payments.

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.

GME payments; distribution; methodology.

Sec. 1740. From the funds appropriated in part 1 for health plan services, the department shall assure that all GME funds continue to be promptly distributed to qualifying hospitals using the methodology developed in consultation with the graduate medical education advisory group during fiscal year 2006-2007.

Interim payments to nursing homes.

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 Medicaid reimbursement funding by public hospital; criteria.

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.

Medicaid health plan; determining 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.

Payment of medical expenses from auto insurer; collection of information.

Sec. 1753. Upon passage of legislation, the department shall collect from auto insurers in this state on a monthly basis information necessary to enable the department to determine whether an individual who is receiving payments of medical expenses from the auto insurer is also a Medicaid recipient. For each individual that the department identifies under this section, the department shall submit a claim for payment to the auto insurer if a Medicaid payment has been made on behalf of the Medicaid recipient. The department shall consult

with auto insurers in this state to establish a system by which information and claims shall be processed.

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 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 of citizenship or legal residency.

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 and that they are residents of this state before approving Medicaid eligibility.

Federal deficit reduction act of 2005; implementation of 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.

Funds recovered by medical services administration; distribution; characteristics; basis.

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.

Actuarially sound rates; certification.

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.

Pharmaceutical dispensing fee structure; findings of negative impact on pharmacist; reexamination.

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. Upon release of the data by the centers for Medicare and Medicaid services, 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 continue a program, the primary goal of which is to enroll all children in foster care in Michigan in a Medicaid health maintenance organization.

Nonemergency transportation services.

Sec. 1773. (1) 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.

(2) The department shall reimburse mileage for nonemergency transportation that encourages contractors to participate.

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 of the current fiscal year 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; report.

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 of the current fiscal year.

(3) The department shall also provide a progress report on ongoing efforts to implement long-term managed care pilot programs to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by June 1 of the current fiscal year.

Reimbursement for Medicaid clients seen in outpatient setting.

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.

Dining assistants; use in nursing homes.

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.

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

Sec. 1780. If congressional action results in an increase in Michigan's federal medical assistance percentage in fiscal year 2008-2009, 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.

Pilot project to demonstrate improvements in efficiency and effectiveness of certain programs.

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.

Coverage for dental root planing and scaling; waiver.

Sec. 1782. The department shall request a waiver from the federal government allowing coverage for dental root planing and scaling in a limited number of counties in the state.

Enrollment of individuals dually eligible for Medicare and Medicaid health plans; conditions.

Sec. 1783. Effective October 1, 2008, the department shall permit the enrollment of individuals dually eligible for Medicare and Medicaid into Medicaid health plans if those health plans also maintain a Medicare advantage special needs plan certified by the centers for Medicare and Medicaid services.

Defined triage or stabilization rate; list of emergency department diagnosis codes.

Sec. 1785. (1) The department shall convene a workgroup to develop and maintain a list of emergency department diagnosis codes to be used to determine payment to hospital facilities for emergency department services provided to Medicaid recipients at a defined triage or stabilization rate.

(2) The reimbursement rate for triage or stabilization shall be equal to the triage rate already in place prior to the implementation of the outpatient prospective payment system.

(3) The workgroup shall include representatives from the department, the Medicaid health plans, and Michigan hospitals that participate in the Medicaid program.

(4) If consensus is reached on a budget-neutral proposal, the department shall implement this payment mechanism for emergency department services in the outpatient prospective payment system by January 1, 2009.

Services where length of stay is less than low-day threshold; reimbursement for inpatient admissions.

Sec. 1786. (1) For services where the actual length of stay is less than the published low-day threshold, reimbursement for inpatient admissions shall be the actual charge multiplied by the individual hospital's cost-to-charge ratio net of indirect medical education, not to exceed the full diagnosis-related group payment rate.

(2) The reimbursement changes specified in subsection (1) shall not be implemented unless the changes are budget-neutral.

(3) The department shall define a low-day threshold of 1 as an inpatient stay of less than 24 hours.

Telephone number of Medicaid beneficiaries.

Sec. 1787. The department shall work with the department of human services to obtain the telephone number of Medicaid beneficiaries and shall provide each Medicaid health plan with the telephone number of that health plan's enrollees on a monthly basis.

Nursing home occupancy ceiling; recommendations; report.

Sec. 1789. The department shall study whether the current nursing home occupancy ceiling is adequate and shall recommend whether to retain the ceiling at 85% or to lower it. The department shall report its findings and recommendations to the state budget director, senate and house appropriations subcommittees on community health, and senate and house fiscal agencies by April 1, 2009.

Primary care and well child visit procedure codes; Medicaid reimbursement rates; increase; report.

Sec. 1791. (1) From the money appropriated in part 1 for physician services and health plan services, $5,285,700.00, of which $2,100,000.00 is general fund/general purpose money, shall be allocated to increase Medicaid reimbursement rates for primary care and well child visit procedure codes. The increased reimbursement rates in this section shall be implemented October 1, 2008 and shall not exceed the comparable Medicare payment rate for the same services.

(2) The money allocated under subsection (1) shall be distributed as a fee-for-service rate increase for primary care procedure codes and as an adjustment paid exclusively to Medicaid managed care organizations for well child visit procedure codes.

(3) By October 1, 2008, the department shall provide a report to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies that identifies the specific procedure codes affected by this section and the amount and percentage increase provided for each procedure code.

Physician quality assurance assessment program.

Sec. 1792. The department shall meet with the Michigan state medical society and the Michigan osteopathic association to discuss the possible structure of a physician quality assurance assessment program.

Prevention of preventable hospitalizations from nursing homes; pilot project.

Sec. 1793. The department shall consider the development of a pilot project that focuses on the prevention of preventable hospitalizations from nursing homes.

Per-person per-day reimbursement for certain hospitals.

Sec. 1794. From the funds appropriated in part 1 for hospital services and therapy, up to $100.00 may be allocated for a program to provide a per-person per-day reimbursement for a hospital located in a city with a population over 500,000.

Sharing of medical records; examination of strategies.

Sec. 1796. The department shall direct the health information technology commission to examine strategies that promote the ability to share medical records. The department shall report the commission's findings by July 1, 2009.

Medicaid recipients with high-cost or complex health conditions; pilot program.

Sec. 1802. The department may spend up to $100,000.00 on a pilot program targeting Medicaid recipients with certain high-cost or complex health conditions. This pilot shall provide financial incentives to primary care physicians to handle disease management responsibilities for these Medicaid recipients.

Identification of veterans.

Sec. 1804. The department, in cooperation with the department of human services, shall work with the federal government's public assistance reporting information system to identify Medicaid recipients who are veterans who may be eligible for federal veterans health care benefits or other benefits.

Personal care services.

Sec. 1805. From the funds appropriated in part 1 for personal care services, beginning October 1, 2008, the department shall increase the monthly Medicaid personal care supplement paid to adult foster care facilities and homes for the aged that provide personal care services to Medicaid beneficiaries by $8.00.

Expansion of county health plans; allocation.

Sec. 1806. From the funds appropriated in part 1 for the county indigent care and third share plans, up to $100.00 may be allocated for the expansion of county health plans.

Mental health services by primary care physicians; establishment of payment mechanism; workgroup; report.

Sec. 1807. (1) The department may convene a workgroup to evaluate and report on the feasibility of establishing a Medicaid payment mechanism for the reimbursement of mental health services by primary care physicians.

(2) The department may report the findings of this workgroup to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies by April 1, 2009.

Ambulance quality assurance assessment program.

Sec. 1808. If legislation is enacted into law, the department shall implement an ambulance quality assurance assessment program. A portion of the assessment shall be retained by the state.

Quality assurance assessment funds; retention.

Sec. 1809. The department is authorized to spend and distribute quality assurance assessment funds as appropriated in this act. The department is authorized to retain funds from the hospital quality assurance assessment program and the long-term care quality assurance assessment program as follows:

(a) Hospital quality assurance assessment program retainer of $117,500,000.00.

(b) Long-term care quality assurance assessment program retainer of $53,893,700.00.

This act is ordered to take immediate effect.
Approved July 17, 2008.
Filed with Secretary of State July 18, 2008.

Compiler's note: Sec. 1809 is repealed by 2008 PA 277.

[No. 247]

(SB 1097)

AN ACT to make appropriations for the department of environmental quality for the fiscal year ending September 30, 2009; to provide for the expenditure of those appropriations; to create certain funds and accounts; to require certain reports; to prescribe the powers and duties of certain state agencies and officials; to authorize certain transfers by certain state agencies; and to provide for the disposition of fees and other income received by the various state agencies.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS

Appropriations; department of environmental quality.

Sec. 101. Subject to the conditions set forth in this act, the amounts listed in this part are appropriated for the department of environmental quality for the fiscal year ending

September 30, 2009, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF ENVIRONMENTAL QUALITY

APPROPRIATION SUMMARY:		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	1,520.7	
GROSS APPROPRIATION	$	363,953,700
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		18,890,200
ADJUSTED GROSS APPROPRIATION	$	345,063,500
Federal revenues:		
Total federal revenues		130,636,100
Special revenue funds:		
Total local revenues		0
Total private revenues		455,700
Total other state restricted revenues		169,559,900
State general fund/general purpose	$	44,411,800
FUND SOURCE SUMMARY:		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	1,520.7	
GROSS APPROPRIATION	$	363,953,700
Interdepartmental grant revenues:		
IDG-MDCH, local public health operations		10,472,500
IDG-MDSP		883,200
IDG, Michigan transportation fund		1,066,900
IDT, interdivisional charges		2,053,400
IDT, laboratory services		4,414,200
Total interdepartmental grants and intradepartmental transfers		18,890,200
ADJUSTED GROSS APPROPRIATION	$	345,063,500
Federal revenues:		
DHHS, federal		6,200
DHS, federal		3,293,800
DOC-NOAA, federal		3,779,400
DOD, federal		1,202,700
DOI, federal		595,300
EPA, multiple		121,758,700
Total federal revenues		130,636,100
Special revenue funds:		
Private funds		455,700
Total private revenues		455,700
Aboveground storage tank fees		363,200
Air emissions fees		9,344,200
Aquifer protection revolving fund		400,000
Campground fund		238,900
Clean Michigan initiative - administration		120,100
Clean Michigan initiative - clean water fund		4,615,800
Cleanup and redevelopment fund		12,428,500
Community pollution prevention fund		250,000
Environmental pollution prevention fund		944,400
Environmental protection fund		3,919,300

	For Fiscal Year Ending Sept. 30, 2009
Environmental response fund	$ 6,320,400
Fees and collections	446,500
Financial instruments	5,000,000
Great Lakes protection fund	1,605,800
Groundwater discharge permit fees	1,120,200
Hazardous materials transportation permit fund	219,700
Infrastructure construction fund	398,000
Laboratory data quality recognition fund	16,100
Land and water permit fees	1,057,600
Landfill maintenance trust fund	56,200
Medical waste emergency response fund	240,900
Metallic mining surveillance fee revenue	94,200
Mineral well regulatory fee revenue	172,500
Nonferrous metallic mineral surveillance	221,700
NPDES fees	3,378,100
Oil and gas regulatory fund	7,860,300
Orphan well fund	2,053,100
Public swimming pool fund	544,300
Public utility assessments	787,400
Public water supply fees	3,962,900
Publication revenue	120,700
Refined petroleum fund	30,724,700
Restricted funds	17,600,700
Retired engineers technical assistance fund	1,474,300
Revitalization revolving loan fund	84,600
Revolving loan revenue bonds	11,400,000
Saginaw Bay and River restoration revenue	175,800
Sand extraction fee revenue	198,600
Scrap tire regulatory fund	5,852,000
Septage waste contingency fund	38,000
Septage waste program fund	722,000
Settlement funds	2,106,400
Sewage sludge land application fee	855,400
Small business pollution prevention revolving loan fund	108,200
Soil erosion and sedimentation control training fund	115,400
Solid waste program fees	4,014,400
Stormwater permit fees	2,814,900
Strategic water quality initiatives fund	10,000,000
Underground storage tank fees	2,134,300
Waste reduction fee revenue	3,909,900
Wastewater operator training fees	172,800
Water analysis fees	3,328,400
Water pollution control revolving fund	3,081,000
Water quality protection fund	100,000
Water use reporting fees	247,100
Total other state restricted revenues	169,559,900
State general fund/general purpose	$ 44,411,800

	For Fiscal Year Ending Sept. 30, 2009
Executive operations and department support.	
Sec. 102. EXECUTIVE OPERATIONS AND DEPARTMENT SUPPORT	
Full-time equated unclassified positions 6.0	
Full-time equated classified positions 83.0	
Unclassified salaries—6.0 FTE positions	$ 587,600
Administrative hearings	446,400
Automated data processing	2,053,400
Central operations—58.0 FTE positions	5,272,300
Environmental ombudsman	250,000
Environmental support projects	5,000,000
Executive direction—18.0 FTE positions	2,316,100
Internal audit services	228,500
Office of the Great Lakes—7.0 FTE positions	1,053,200
Building occupancy charges	7,116,600
Rent - privately owned property	2,145,900
GROSS APPROPRIATION	$ 26,470,000
Appropriated from:	
Interdepartmental grant revenues:	
IDG-MDSP	112,300
IDT, interdivisional charges	2,053,400
IDT, laboratory services	472,800
Federal revenues:	
DOC-NOAA, federal	22,600
DOI, federal	160,900
EPA, multiple	195,200
Special revenue funds:	
Financial instruments	5,000,000
Great Lakes protection fund	605,800
Restricted funds	12,394,500
Settlement funds	104,900
State general fund/general purpose	$ 5,347,600
Air quality.	
Sec. 103. AIR QUALITY	
Full-time equated classified positions 236.5	
Air quality programs—236.5 FTE positions	$ 26,092,000
GROSS APPROPRIATION	$ 26,092,000
Appropriated from:	
Federal revenues:	
DHS, federal	1,708,400
EPA, multiple	4,492,700
Special revenue funds:	
Air emissions fees	8,952,900
Environmental response fund	106,700
Fees and collections	301,600

Compiler's note: The shaded text was vetoed by the Governor, whose veto message appears in this volume under the heading "Vetoes."

		For Fiscal Year Ending Sept. 30, 2009
Oil and gas regulatory fund	$	108,200
Refined petroleum fund		2,864,800
State general fund/general purpose	$	7,556,700

Environmental science and services.

Sec. 104. ENVIRONMENTAL SCIENCE AND SERVICES

Full-time equated classified positions....175.0		
Program services and grant management—30.0 FTE positions	$	4,000,900
Laboratory services—60.0 FTE positions		7,045,800
Municipal assistance—37.0 FTE positions		5,323,900
Pollution prevention and technical assistance—48.0 FTE positions..		5,017,200
Pollution prevention outreach		300,000
Retired engineers technical assistance program		1,474,300
GROSS APPROPRIATION	$	23,162,100
Appropriated from:		
Interdepartmental grant revenues:		
IDT, laboratory services		3,790,500
Federal revenues:		
DOC-NOAA, federal		454,800
EPA, multiple		3,445,800
Special revenue funds:		
Private funds		300,000
Air emissions fees		391,300
Environmental protection fund		68,900
Environmental response fund		665,100
Laboratory data quality recognition fund		16,100
Public water supply fees		253,000
Retired engineers technical assistance fund		1,474,300
Revitalization revolving loan fund		84,600
Settlement funds		235,200
Small business pollution prevention revolving loan fund		108,200
Stormwater permit fees		95,900
Strategic water quality initiatives fund		400,000
Waste reduction fee revenue		3,835,000
Wastewater operator training fees		172,800
Water analysis fees		3,328,400
Water pollution control revolving fund		2,409,100
State general fund/general purpose	$	1,633,100

Office of geological survey.

Sec. 105. OFFICE OF GEOLOGICAL SURVEY

Full-time equated classified positions....67.0		
Coal and sand dune management—2.0 FTE positions	$	627,000
Metallic mine reclamation—1.0 FTE position		94,200
Mineral wells management—2.0 FTE positions		247,400
Nonferrous metallic mining—2.0 FTE positions		221,700
Orphan well—2.0 FTE positions		2,053,100
Services to oil and gas—58.0 FTE positions		7,509,500
GROSS APPROPRIATION	$	10,752,900

		For Fiscal Year Ending Sept. 30, 2009
Appropriated from:		
Federal revenues:		
DOI, federal	$	428,400
Special revenue funds:		
Metallic mining surveillance fee revenue		94,200
Mineral well regulatory fee revenue		172,500
Nonferrous metallic mineral surveillance		221,700
Oil and gas regulatory fund		7,388,800
Orphan well fund		2,053,100
Publication revenue		120,700
Sand extraction fee revenue		198,600
State general fund/general purpose	$	74,900

Land and water management.

Sec. 106. LAND AND WATER MANAGEMENT

Full-time equated classified positions....121.0		
Program direction—6.0 FTE positions	$	944,100
Field permitting and project assistance—72.0 FTE positions		7,549,600
Great Lakes shorelands—24.0 FTE positions		2,672,700
Water management—19.0 FTE positions		2,702,900
GROSS APPROPRIATION	$	13,869,300
Appropriated from:		
Interdepartmental grant revenues:		
IDG, Michigan transportation fund		1,012,300
Federal revenues:		
DHS, federal		1,003,500
DOC-NOAA, federal		1,515,800
EPA, multiple		1,052,100
Special revenue funds:		
Land and water permit fees		705,100
State general fund/general purpose	$	8,580,500

Remediation and redevelopment.

Sec. 107. REMEDIATION AND REDEVELOPMENT

Full-time equated classified positions....285.0		
Contaminated site investigation, cleanup, and revitalization—225.0 FTE positions	$	23,005,400
Federal cleanup project management—60.0 FTE positions		8,411,400
Emergency cleanup actions		4,000,000
Refined petroleum product cleanup program		20,000,000
Environmental cleanup support		2,340,000
Superfund cleanup		4,000,000
GROSS APPROPRIATION	$	61,756,800
Appropriated from:		
Federal revenues:		
DHHS, federal		6,200
DOD, federal		1,174,500
EPA, multiple		8,403,500

		For Fiscal Year Ending Sept. 30, 2009
Special revenue funds:		
Private funds	$	155,700
Cleanup and redevelopment fund		12,428,500
Environmental protection fund		3,850,400
Environmental response fund		5,248,000
Landfill maintenance trust fund		56,200
Refined petroleum fund		26,813,500
Settlement funds		1,516,300
State general fund/general purpose	$	2,104,000

Waste and hazardous materials.

Sec. 108. WASTE AND HAZARDOUS MATERIALS

Full-time equated classified positions....173.0		
Aboveground storage tank program—8.0 FTE positions	$	762,900
Hazardous waste management program—60.0 FTE positions		6,497,200
Low-level radioactive waste authority—2.0 FTE positions		787,400
Medical waste program—2.0 FTE positions		240,900
Radiological protection program—12.0 FTE positions		1,423,100
Scrap tire regulatory program—11.0 FTE positions		1,066,800
Solid waste management program—45.0 FTE positions		4,587,700
Underground storage tank program—33.0 FTE positions		3,402,900
GROSS APPROPRIATION	$	18,768,900
Appropriated from:		
Interdepartmental grant revenues:		
IDG-MDSP		742,900
Federal revenues:		
EPA, multiple		4,027,500
Special revenue funds:		
Aboveground storage tank fees		363,200
Environmental pollution prevention fund		944,400
Hazardous materials transportation permit fund		219,700
Medical waste emergency response fund		240,900
Public utility assessments		787,400
Scrap tire regulatory fund		1,066,800
Solid waste program fees		4,014,400
Underground storage tank fees		2,134,300
Waste reduction fee revenue		74,900
State general fund/general purpose	$	4,152,500

Water.

Sec. 109. WATER

Full-time equated classified positions....358.2		
Aquifer protection program	$	350,000
Aquifer protection and dispute resolution - IDG to Michigan department of agriculture		50,000
Drinking water and environmental health—120.0 FTE positions		16,176,600
Expedited water/wastewater permits—3.0 FTE positions		398,000
Fish contaminant monitoring		316,100