		For Fiscal Year Ending Sept. 30, 2005
Special revenue funds:		
Total private revenues	$	2,655,700
Total other state restricted revenues		7,728,600
State general fund/general purpose	$	4,657,300

Laboratory services.

Sec. 109. LABORATORY SERVICES

Full-time equated classified positions....121.0		
Bovine tuberculosis—2.0 FTE positions	$	500,000
Laboratory services—119.0 FTE positions		14,380,400
GROSS APPROPRIATION	$	14,880,400
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from environmental quality		406,000
Federal revenues:		
Total federal revenues		2,819,900
Special revenue funds:		
Total other state restricted revenues		4,785,800
State general fund/general purpose	$	6,868,700

Epidemiology.

Sec. 110. EPIDEMIOLOGY

Full-time equated classified positions....107.9		
AIDS surveillance and prevention program	$	1,887,800
Asthma prevention and control—2.3 FTE positions		1,036,800
Bioterrorism preparedness—59.5 FTE positions		51,902,200
Epidemiology administration—41.1 FTE positions		6,233,600
Newborn screening follow-up and treatment services—5.0 FTE positions		3,712,500
Tuberculosis control and recalcitrant AIDS program		867,000
GROSS APPROPRIATION	$	65,639,900
Appropriated from:		
Federal revenues:		
Total federal revenues		59,642,500
Special revenue funds:		
Total private revenues		77,500
Total other state restricted revenues		3,893,500
State general fund/general purpose	$	2,026,400

Local health administration and grants.

Sec. 111. LOCAL HEALTH ADMINISTRATION AND GRANTS

Full-time equated classified positions....7.0		
Implementation of 1993 PA 133, MCL 333.17015	$	100,000
Lead abatement program—7.0 FTE positions		1,728,400
Local health services		220,000
Local public health operations		40,618,400
Medical services cost reimbursement to local health departments		1,800,000
GROSS APPROPRIATION	$	44,466,800

	For Fiscal Year Ending Sept. 30, 2005
Appropriated from:	
Federal revenues:	
Total federal revenues	$ 3,291,000
Special revenue funds:	
Total other state restricted revenues	480,900
State general fund/general purpose	$ 40,694,900

Chronic disease and injury prevention and health promotion.

Sec. 112. CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Full-time equated classified positions....49.8	
African-American male health initiative	$ 106,700
AIDS and risk reduction clearinghouse and media campaign	1,576,000
Alzheimer's information network	550,000
Cancer prevention and control program—14.3 FTE positions	14,743,800
Chronic disease prevention—1.0 FTE position	5,334,300
Diabetes and kidney program—9.1 FTE positions	3,571,900
Health education, promotion, and research programs—9.3 FTE positions	1,018,100
Injury control intervention project—1.0 FTE position	520,100
Michigan Parkinson's foundation	200,000
Morris Hood Wayne State University diabetes outreach	400,000
Physical fitness, nutrition, and health	1,000,000
Public health traffic safety coordination	564,500
Smoking prevention program—13.1 FTE positions	6,414,600
Tobacco tax collection and enforcement	810,000
Violence prevention—2.0 FTE positions	1,779,600
GROSS APPROPRIATION	$ 38,589,600
Appropriated from:	
Federal revenues:	
Total federal revenues	18,440,700
Special revenue funds:	
Total other state restricted revenues	18,168,700
State general fund/general purpose	$ 1,980,200

Family, maternal, and children's health services.

Sec. 113. FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES

Full-time equated classified positions....45.4	
Childhood lead program—5.8 FTE positions	$ 2,492,600
Dental programs	485,400
Dental program for persons with developmental disabilities	151,000
Early childhood collaborative secondary prevention	524,000
Family, maternal, and children's health services administration—39.6 FTE positions	4,581,200
Family planning local agreements	12,270,300

		For Fiscal Year Ending Sept. 30, 2005
Local MCH services	$	7,264,200
Migrant health care		612,200
Pediatric AIDS prevention and control		1,176,800
Pregnancy prevention program		5,846,100
Prenatal care outreach and service delivery support		3,049,300
School health and education programs		1,000,000
Special projects		6,213,400
Sudden infant death syndrome program		321,300
GROSS APPROPRIATION	$	45,987,800
Appropriated from:		
Federal revenues:		
Total federal revenues		31,572,400
Special revenue funds:		
Total other state restricted revenues		8,904,000
State general fund/general purpose	$	5,511,400

Women, infants, and children food and nutrition program.

Sec. 114. WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Full-time equated classified positions	41.0	
Women, infants, and children program administration and special projects—41.0 FTE positions	$	5,702,700
Women, infants, and children program local agreements and food costs		181,392,100
GROSS APPROPRIATION	$	187,094,800
Appropriated from:		
Federal revenues:		
Total federal revenues		136,747,500
Special revenue funds:		
Total private revenues		50,347,300
State general fund/general purpose	$	0

Children's special health care services.

Sec. 115. CHILDREN'S SPECIAL HEALTH CARE SERVICES

Full-time equated classified positions	47.7	
Children's special health care services administration—47.7 FTE positions	$	4,319,700
Amputee program		184,600
Bequests for care and services		1,754,600
Case management services		3,773,500
Conveyor contract		513,500
Medical care and treatment		172,774,200
GROSS APPROPRIATION	$	183,320,100
Appropriated from:		
Federal revenues:		
Total federal revenues		88,284,700

		For Fiscal Year Ending Sept. 30, 2005
Special revenue funds:		
Total private revenues	$	1,000,000
Total other state restricted revenues		650,000
State general fund/general purpose	$	93,385,400

Office of drug control policy.

Sec. 116. OFFICE OF DRUG CONTROL POLICY

Full-time equated classified positions 16.0		
Drug control policy—16.0 FTE positions	$	2,040,800
Anti-drug abuse grants		26,859,200
Interdepartmental grant to judiciary for drug treatment courts		1,800,000
GROSS APPROPRIATION	$	30,700,000
Appropriated from:		
Federal revenues:		
Total federal revenues		30,334,200
State general fund/general purpose	$	365,800

Crime victim services commission.

Sec. 117. CRIME VICTIM SERVICES COMMISSION

Full-time equated classified positions 9.0		
Grants administration services—9.0 FTE positions	$	1,137,300
Justice assistance grants		13,000,000
Crime victim rights services grants		8,985,300
GROSS APPROPRIATION	$	23,122,600
Appropriated from:		
Federal revenues:		
Total federal revenues		13,954,700
Special revenue funds:		
Total other state restricted revenues		9,167,900
State general fund/general purpose	$	0

Office of services to the aging.

Sec. 118. OFFICE OF SERVICES TO THE AGING

Full-time equated classified positions 36.5		
Commission (per diem $50.00)	$	10,500
Office of services to aging administration—36.5 FTE positions		4,952,400
Community services		35,404,200
Nutrition services		37,290,500
Senior volunteer services		5,645,900
Senior citizen centers staffing and equipment		1,068,700
Employment assistance		2,818,300
Respite care program		7,600,000
GROSS APPROPRIATION	$	94,790,500
Appropriated from:		
Federal revenues:		
Total federal revenues		52,038,500
Special revenue funds:		
Total private revenues		20,000

		For Fiscal Year Ending Sept. 30, 2005
Tobacco settlement trust fund	$	5,000,000
Total other state restricted revenues		2,767,000
State general fund/general purpose	$	34,965,000

Medical services administration.

Sec. 119. MEDICAL SERVICES ADMINISTRATION

Full-time equated classified positions....339.7		
Medical services administration—339.7 FTE positions	$	47,398,100
Facility inspection contract - state police		132,800
MIChild administration		4,327,800
GROSS APPROPRIATION	$	51,858,700
Appropriated from:		
Federal revenues:		
Total federal revenues		35,377,400
Special revenue funds:		
State general fund/general purpose	$	16,481,300

Medical services.

Sec. 120. MEDICAL SERVICES

Hospital services and therapy	$	1,186,087,500
Hospital disproportionate share payments		50,000,000
Physician services		239,908,200
Medicare premium payments		233,705,600
Pharmaceutical services		732,084,000
Home health services		47,158,200
Transportation		8,538,300
Auxiliary medical services		101,301,900
Ambulance services		11,000,000
Long-term care services		1,689,989,700
Elder prescription insurance coverage		19,500,000
Health plan services		1,748,749,000
MIChild program		36,875,600
Medicaid adult benefits waiver		138,991,900
Maternal and child health		9,234,500
Social services to the physically disabled		1,344,900
Medical expenses recoupment		(23,113,000)
Subtotal basic medical services program		6,231,356,300
School-based services		63,609,100
Special adjustor payments		522,451,700
Subtotal special medical services payments		586,060,800
GROSS APPROPRIATION	$	6,817,417,100
Appropriated from:		
Federal revenues:		
Total federal revenues		3,935,316,000
Special revenue funds:		
Total local revenues		362,852,100

		For Fiscal Year Ending Sept. 30, 2005
Merit award trust fund	$	110,675,000
Tobacco settlement trust fund		61,125,000
Total other state restricted revenues		1,180,624,400
State general fund/general purpose	$	1,166,824,600

Information technology.

Sec. 121. INFORMATION TECHNOLOGY

Information technology services and projects	$	30,481,900
GROSS APPROPRIATION	$	30,481,900
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of corrections		146,800
Federal revenues:		
Total federal revenues		17,816,000
Special revenue funds:		
Total other state restricted revenues		2,570,300
State general fund/general purpose	$	9,948,800

PART 2

PROVISIONS CONCERNING APPROPRIATIONS

GENERAL SECTIONS

Total state spending; payments to local units of government.

Sec. 201. Pursuant to section 30 of article IX of the state constitution of 1963, total state spending from state resources under part 1 for fiscal year 2004-2005 is $4,021,911,100.00 and state spending from state resources to be paid to units of local government for fiscal year 2004-2005 is $1,054,030,900.00. The itemized statement below identifies appropriations from which spending to units of local government will occur:

DEPARTMENT OF COMMUNITY HEALTH		
DEPARTMENTWIDE ADMINISTRATION		
Departmental administration and management	$	11,087,100
Rural health services		35,000
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS		
Mental health initiatives for older persons		1,049,200
COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS		
State disability assistance program substance abuse services		2,509,800
Community substance abuse prevention, education, and treatment programs		18,590,500
Medicaid mental health services		586,547,000
Community mental health non-Medicaid services		313,352,400

Medicaid adult benefits waiver	$	12,120,000
Multicultural services		4,963,800
Medicaid substance abuse services		12,438,200
Respite services		1,000,000
Omnibus budget reconciliation act implementation		3,859,500
INFECTIOUS DISEASE CONTROL		
AIDS prevention, testing and care programs		2,031,100
Immunization local agreements		2,973,900
Sexually transmitted disease control local agreements		406,100
LOCAL HEALTH ADMINISTRATION AND GRANTS		
Local public health operations		40,618,400
CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION		
Smoking prevention program		1,960,300
FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES		
Childhood lead program		106,900
Family planning local agreements		2,094,400
Local MCH services		246,100
Prenatal care outreach and service delivery support		610,000
School health and education programs		500,000
CHILDREN'S SPECIAL HEALTH CARE SERVICES		
Case management services		3,169,900
CRIME VICTIM SERVICES COMMISSION		
Crime victim rights services grants		6,381,300
OFFICE OF SERVICES TO THE AGING		
Community services		12,148,400
Nutrition services		11,538,800
Senior volunteer services		517,500
MEDICAL SERVICES		
Transportation		1,175,300
TOTAL OF PAYMENTS TO LOCAL UNITS OF GOVERNMENT	$	1,054,030,900

Appropriations subject to MCL 18.1101 to 18.1594.

Sec. 202. (1) The appropriations authorized under this act are subject to the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

(2) Funds for which the state is acting as the custodian or agent are not subject to annual appropriation.

Definitions.

Sec. 203. As used in this act:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "CMHSP" means a community mental health services program as that term is defined in section 100a of the mental health code, 1974 PA 258, MCL 330.1100a.

(c) "Disease management" means a comprehensive system that incorporates the patient, physician, and health plan into 1 system with the common goal of achieving desired outcomes for patients.

(d) "Department" means the Michigan department of community health.

(e) "DSH" means disproportionate share hospital.

(f) "EPIC" means elder prescription insurance coverage program.

(g) "EPSDT" means early and periodic screening, diagnosis, and treatment.

(h) "FTE" means full-time equated.

(i) "GME" means graduate medical education.

(j) "Health plan" means, at a minimum, an organization that meets the criteria for delivering the comprehensive package of services under the department's comprehensive health plan.

(k) "HIV/AIDS" means human immunodeficiency virus/acquired immune deficiency syndrome.

(*l*) "HMO" means health maintenance organization.

(m) "IDEA" means individual disability education act.

(n) "IDG" means interdepartmental grant.

(o) "MCH" means maternal and child health.

(p) "MIChild" means the program described in section 1670.

(q) "MSS/ISS" means maternal and infant support services.

(r) "Specialty prepaid health plan" means a program described in section 232b of the mental health code, 1974 PA 258, MCL 330.1232b.

(s) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395hhh.

(t) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396v.

(u) "Title XX" means title XX of the social security act, 49 USC 1397 to 1397f.

(v) "WIC" means women, infants, and children supplemental nutrition program.

Billing by department of civil service.

Sec. 204. The department of civil service shall bill the department at the end of the first fiscal quarter for the 1% charge authorized by section 5 of article XI of the state constitution of 1963. Payments shall be made for the total amount of the billing by the end of the second fiscal quarter.

Hiring freeze; exceptions.

Sec. 205. (1) A hiring freeze shall be imposed on the state classified civil service. State departments and agencies are prohibited from hiring any new state classified civil service employees and prohibited from filling any vacant state classified civil service positions. This hiring freeze does not apply to internal transfers of classified employees from 1 position to another within a department.

(2) The state budget director shall grant exceptions to this hiring freeze when the state budget director believes that the hiring freeze will result in rendering a state department or agency unable to deliver basic services, cause loss of revenue to the state, result in the inability of the state to receive federal funds, or would necessitate additional

expenditures that exceed any savings from maintaining the vacancy. The state budget director shall report quarterly to the chairpersons of the senate and house of representatives standing committees on appropriations the number of exceptions to the hiring freeze approved during the previous quarter and the reasons to justify the exception.

Reporting requirements; use of Internet.

Sec. 208. Unless otherwise specified, the department shall use the Internet to fulfill the reporting requirements of this act. This requirement may include transmission of reports via electronic mail to the recipients identified for each reporting requirement or it may include placement of reports on the Internet or Intranet site.

Purchase of foreign goods or services.

Sec. 209. (1) Funds appropriated in part 1 shall not be used for the purchase of foreign goods or services, or both, if competitively priced and comparable quality American goods or services, or both, are available.

(2) Funds appropriated in part 1 shall not be used for the purchase of out-of-state goods or services, or both, if competitively priced and comparable quality Michigan goods or services, or both, are available.

Carrying forward revenue from fees and collections.

Sec. 211. If the revenue collected by the department from fees and collections exceeds the amount appropriated in part 1, the revenue may be carried forward with the approval of the state budget director into the subsequent fiscal year. The revenue carried forward under this section shall be used as the first source of funds in the subsequent fiscal year.

Federal maternal and child health block grant, preventive health and health services block grant, substance abuse block grant, healthy Michigan fund, and Michigan health initiative funds; sources of revenue.

Sec. 212. (1) From the amounts appropriated in part 1, no greater than the following amounts are supported with federal maternal and child health block grant, preventive health and health services block grant, substance abuse block grant, healthy Michigan fund, and Michigan health initiative funds:

(a) Maternal and child health block grant	$	21,714,000
(b) Preventive health and health services block grant		5,081,300
(c) Substance abuse block grant		60,269,400
(d) Healthy Michigan fund		43,400,000
(e) Michigan health initiative		9,834,100

(2) On or before February 1, 2005, the department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on the detailed name and amounts of federal, restricted, private, and local sources of revenue that support the appropriations in each of the line items in part 1 of this act.

(3) Upon the release of the fiscal year 2005-2006 executive budget recommendation, the department shall report to the same parties in subsection (2) on the amounts and detailed sources of federal, restricted, private, and local revenue proposed to support the total funds appropriated in each of the line items in part 1 of the fiscal year 2005-2006 executive budget proposal.

(4) The department shall provide to the same parties in subsection (2) all revenue source detail for consolidated revenue line item detail upon request to the department.

Departments, agencies, and commissions receiving tobacco tax funds; report.

Sec. 213. The state departments, agencies, and commissions receiving tobacco tax funds from part 1 shall report by January 1, 2005, to the senate and house of representatives appropriations committees, the senate and house fiscal agencies, and the state budget director on the following:

(a) Detailed spending plan by appropriation line item including description of programs.

(b) Description of allocations or bid processes including need or demand indicators used to determine allocations.

(c) Eligibility criteria for program participation and maximum benefit levels where applicable.

(d) Outcome measures to be used to evaluate programs.

(e) Any other information considered necessary by the house of representatives or senate appropriations committees or the state budget director.

State-restricted tobacco tax revenue; use for lobbying prohibited.

Sec. 214. The use of state-restricted tobacco tax revenue received for the purpose of tobacco prevention, education, and reduction efforts and deposited in the healthy Michigan fund shall not be used for lobbying as defined in 1978 PA 472, MCL 4.411 to 4.431, and shall not be used in attempting to influence the decisions of the legislature, the governor, or any state agency.

Reimbursements, refunds, adjustments, and settlements from prior years.

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

(2) The department's ability to satisfy appropriation deductions in part 1 shall not be limited to collections and accruals pertaining to services provided in fiscal year 2004-2005, but shall also include reimbursements, refunds, adjustments, and settlements from prior years.

(3) The department shall report by March 15, 2005 to the house of representatives and senate appropriations subcommittees on community health on all reimbursements, refunds, adjustments, and settlements from prior years.

Basic health services.

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

Design and implementation of public health related activities and projects; contract with Michigan public health institute; report.

Sec. 219. (1) The department may contract with the Michigan public health institute for the design and implementation of projects and for other public health related activities prescribed in section 2611 of the public health code, 1978 PA 368, MCL 333.2611. The department may develop a master agreement with the institute to carry out these purposes for up to a 3-year period. The department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on or before November 1, 2004 and May 1, 2005 all of the following:

(a) A detailed description of each funded project.

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

(c) The expected project duration.

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

(2) If a report required under subsection (1) is not received by the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on or before the date specified for that report, the disbursement of funds to the Michigan public health institute under this section shall stop. The disbursement of those funds shall recommence when the overdue report is received.

(3) On or before September 30, 2005, the department shall provide to the same parties listed in subsection (1) a copy of all reports, studies, and publications produced by the Michigan public health institute, its subcontractors, or the department with the funds appropriated in part 1 and allocated to the Michigan public health institute.

Michigan public health institute; submission to audits.

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

Publications, videos, conferences, and workshops; fees.

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

Technology-related services and projects; payment of user fees to department of information technology.

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

Information technology funds; designation as work project.

Sec. 260. Amounts appropriated in part 1 for information technology may be designated as work projects and carried forward to support technology projects under the

direction of the department of information technology. Funds designated in this manner are not available for expenditure until approved as work projects under section 451a of the management and budget act, 1984 PA 431, MCL 18.1451a.

Submission of Medicaid waiver, Medicaid state plan amendment, or similar proposal; notice.

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

Receipt and retention of reports.

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

Out-of-state travel.

Sec. 266. (1) Due to the current budgetary problems in this state, out-of-state travel for the fiscal year ending September 30, 2005 shall be limited to situations in which 1 or more of the following conditions apply:

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

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

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

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

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

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

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

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

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

(b) The destination of each travel occurrence.

(c) The dates of each travel occurrence.

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

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

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

DEPARTMENTWIDE ADMINISTRATION

Payments in lieu of worker's compensation benefits.

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

Mental health services; first-party payment.

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

Loan repayment for dentists.

Sec. 304. 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.

Multicultural agencies providing primary care services.

Sec. 305. The department is directed to continue support of multicultural agencies that provide primary care services from the funds appropriated in part 1.

Federally qualified health centers; service capacity.

Sec. 307. From the funds appropriated in part 1 for primary care services, an amount not to exceed $3,048,900.00 is appropriated to enhance the service capacity of the federally qualified health centers and other health centers which are similar to federally qualified health centers.

Operation of health center serving Barry county.

Sec. 308. From the funds appropriated in part 1 for primary care services, $250,000.00 shall be allocated to a pilot project to support operation of a health center that serves the uninsured, underinsured, and Medicaid population of Barry County who are not currently being served. Physicians shall provide services to the health center on a voluntary basis.

Compulsive gambling.

Sec. 313. By November 1, 2004, the department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on activities undertaken by the department to address compulsive gambling.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Contract with protection and advocacy service.

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

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Local CMHSP or specialty prepaid health plans.

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

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

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

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

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

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

(f) A system of continuous quality improvement.

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

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

Contracts between department and CMHSPs or specialty prepaid health plans.

Sec. 402. (1) From funds appropriated in part 1, final authorizations to CMHSPs or specialty prepaid health plans shall be made upon the execution of contracts between the department and CMHSPs or specialty prepaid health plans. The contracts shall contain an approved plan and budget as well as policies and procedures governing the obligations and responsibilities of both parties to the contracts. Each contract with a CMHSP or specialty prepaid health plan that the department is authorized to enter into under this subsection shall include a provision that the contract is not valid unless the total dollar obligation for all of the contracts between the department and the CMHSPs or specialty prepaid health plans entered into under this subsection for fiscal year 2004-2005 does not exceed the amount of money appropriated in part 1 for the contracts authorized under this subsection.

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

(a) Any new contracts with CMHSPs or specialty prepaid health plans that would affect rates or expenditures are enacted.

(b) Any amendments to contracts with CMHSPs or specialty prepaid health plans that would affect rates or expenditures are enacted.

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

Contracts between multicultural service providers and CMHSPs or specialty prepaid health plans.

Sec. 403. From the funds appropriated in part 1 for multicultural services, the department shall ensure that CMHSPs or specialty prepaid health plans continue contracts with multicultural services providers.

Community mental health services programs; report.

Sec. 404. (1) Not later than May 31 of each fiscal year, the department shall provide a report on the community mental health services programs to the members of the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director that includes the information required by this section.

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

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

(b) When the encounter data is available, a breakdown of clients served, by diagnosis. As used in this subdivision, "diagnosis" means a recipient's primary diagnosis, stated as a specifically named mental illness, emotional disorder, or developmental disability corresponding to terminology employed in the latest edition of the American psychiatric association's diagnostic and statistical manual.

(c) Per capita expenditures by client population group.

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

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

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

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

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

(*iii*) The number of people requesting services who are on waiting lists for services.

(*iv*) The average length of time that people remained on waiting lists for services.

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

(h) An analysis of information provided by community mental health service programs in response to the needs assessment requirements of the mental health code, including

information about the number of persons in the service delivery system who have requested and are clinically appropriate for different services.

(i) An estimate of the number of FTEs employed by the CMHSPs or specialty prepaid health plans or contracted with directly by the CMHSPs or specialty prepaid health plans as of September 30, 2004 and an estimate of the number of FTEs employed through contracts with provider organizations as of September 30, 2004.

(j) Lapses and carryforwards during fiscal year 2003-2004 for CMHSPs or specialty prepaid health plans.

(k) Contracts for mental health services entered into by CMHSPs or specialty prepaid health plans with providers, including amount and rates, organized by type of service provided.

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

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

(*ii*) Performance indicator information required to be submitted to the department in the contracts with CMHSPs or specialty prepaid health plans.

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

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

Payments to direct care workers.

Sec. 405. It is the intent of the legislature that the employee wage pass-through funded in previous years to the community mental health services programs for direct care workers in local residential settings and for paraprofessional and other nonprofessional direct care workers in day programs, supported employment, and other vocational programs shall continue to be paid to direct care workers.

State disability assistance substance abuse services program; eligibility.

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

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

Mental illness and substance abuse; contracts with coordinating agencies or designated service providers; fee schedule.

Sec. 407. (1) The amount appropriated in part 1 for substance abuse prevention, education, and treatment grants shall be expended for contracting with coordinating agencies or designated service providers. It is the intent of the legislature that the coordinating agencies and designated service providers work with the CMHSPs or

specialty prepaid health plans to coordinate the care and services provided to individuals with both mental illness and substance abuse diagnoses.

(2) The department shall establish a fee schedule for providing substance abuse services and charge participants in accordance with their ability to pay. Any changes in the fee schedule shall be developed by the department with input from substance abuse coordinating agencies.

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

Sec. 408. (1) By April 15, 2005, the department shall report the following data from fiscal year 2003-2004 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.

Service providers furnishing child care services; funding 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 condition of eligibility for public assistance.

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

Mental health jail diversion services.

Sec. 411. (1) The department shall ensure that each contract with a CMHSP or specialty prepaid health plan requires the CMHSP or specialty prepaid health plan 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 specialty prepaid health plan 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.

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 2003-2004.

Managed care plan for specialized substance abuse services.

Sec. 414. Medicaid substance abuse treatment services shall be managed by selected CMHSPs or specialty prepaid health plans 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 CMHSPs or specialty prepaid health plans 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 CMHSPs or specialty prepaid health plans shall be responsible for the reimbursement of claims for specialized substance abuse services. The CMHSPs or specialty prepaid health plans 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 health care program; report.

Sec. 418. On or before the tenth of each month, the department shall report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the amount of funding paid to the CMHSPs or specialty prepaid health plans to support the Medicaid-managed mental health care program in that month. The information shall include the total paid to each CMHSP or specialty prepaid health plan, per capita rate paid for each eligibility group for each CMHSP or specialty prepaid health plan, and number of cases in each eligibility group for each CMHSP or specialty prepaid health plan, and year-to-date summary of eligibles and expenditures for the Medicaid-managed mental health care program.

Delivery of services; cooperative effort.

Sec. 423. The department shall work cooperatively with the family independence agency and the departments of 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. The department shall report by March 15, 2005 on the outcomes of this cooperative effort to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

Claims; processing and payment.

Sec. 424. Each community mental health services program or specialty prepaid health plan that contracts with the department to provide services to the Medicaid population shall adhere to the following timely claims processing and payment procedure for claims submitted by health professionals and facilities:

(a) A "clean claim" as described in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i, must be paid within 45 days after receipt of the claim by the community

mental health services program or specialty prepaid health plan. A clean claim that is not paid within this time frame shall bear simple interest at a rate of 12% per annum.

(b) A community mental health services program or specialty prepaid health plan 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 community mental health services program or specialty prepaid health plan shall pay the claim within 30 days after the defect is corrected.

Prisoners receiving substance abuse services; report.

Sec. 425. By April 1, 2005, the department, in conjunction with the department of corrections, shall report the following data from fiscal year 2003-2004 on mental health and substance abuse services to the house of representatives and senate appropriations subcommittees on community health and corrections, the house and senate fiscal agencies, and the state budget office:

(a) The number of prisoners receiving substance abuse services, which shall include a description and breakdown of the type of substance abuse services provided to prisoners.

(b) The number of prisoners receiving mental health services, which shall include a description and breakdown of the type of mental health services provided to prisoners.

(c) Data indicating if prisoners receiving mental health services were previously hospitalized in a state psychiatric hospital for persons with mental illness.

Local funds used as state matching funds.

Sec. 428. (1) Each CMHSP and affiliation of CMHSPs 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 CMHSPs and affiliations of CMHSPs. 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 CMHSP or an affiliation of CMHSPs.

(2) The distribution of the aforementioned increases in the capitation payment rates, if any, shall be based on a formula developed by a committee established by the department, including representatives from CMHSPs or affiliations of CMHSPs and department staff.

Matching funds paid by county; 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, 2004.

Moving adults with mental illness from state psychiatric hospitals to community residential settings.

Sec. 439. (1) It is the intent of the legislature that the department, in conjunction with CMHSPs, support pilot projects that facilitate the movement of adults with mental illness from state psychiatric hospitals to community residential settings.

(2) The purpose of the pilot projects is to encourage the placement of persons with mental illness in community residential settings who may require any of the following:

(a) A secured and supervised living environment.

(b) Assistance in taking prescribed medications.

(c) Intensive case management services.

(d) Assertive community treatment team services.

(e) Alcohol or substance abuse treatment and counseling.

(f) Individual or group therapy.

(g) Day or partial day programming activities.

(h) Vocational, educational, or self-help training or activities.

(i) Other services prescribed to treat a person's mental illness to prevent the need for hospitalization.

(3) The pilot projects described in this section shall be completely voluntary.

(4) The department shall provide semiannual reports to the house of representatives and senate appropriations subcommittees on community health, the state budget office, and the house and senate fiscal agencies as to any activities undertaken by the department and CMHSPs for pilot projects implemented under this section.

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 eligible for mental health services under the priority population sections of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106, will receive mandated services under this plan.

(3) Capitation payments to CMHSPs or specialty prepaid health plans 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 or specialty prepaid health plans.

(5) In the waiver renewal application the department submits to the centers for Medicare and Medicaid services for continuation of the state's 1915(b) specialty services waiver, the department will request that the amount of savings that may be retained by a specialty prepaid health plan be changed from 5% to 7.5% of aggregate capitation payments. If the department is unable to secure centers for Medicare and Medicaid services approval for this change, the department shall allow specialty prepaid health plans and their affiliate CMHSP members to retain 50% of the unspent general fund/general purpose portion of the funds allocated to the specialty prepaid health plan for services to be provided under the Medicaid specialty services waiver. Any such general fund/general purpose portion retained by the specialty prepaid health plan and its CMHSP affiliates under this section shall be considered as state revenues for purposes of determining the

amount of state funds that the CMHSP may carry forward under section 226(2)(c) of the mental health code, 1974 PA 258, MCL 330.1226.

Streamlining audit and reporting requirements; recommendations.

Sec. 450. The department shall continue a work group comprised of CMHSPs or specialty prepaid health plans and departmental staff to recommend strategies to streamline audit and reporting requirements for CMHSPs or specialty prepaid health plans. The department shall report on the recommendations of the work group by March 31, 2005 to the house of representatives and senate appropriations subcommittees on community health, the house fiscal agency, the senate fiscal agency, and the state budget director.

Implementation of retroactive policy.

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

Federal substance abuse block grant work group; sharing findings.

Sec. 453. By December 1, 2004, the department shall share with the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies the findings of their federal substance abuse block grant work group.

Sec. 454. (1) From the funds appropriated in part 1 for mental health/substance abuse program administration, $50,000.00 shall be used to conduct a study of the feasibility for increased coordination and collaboration among community health and human services agencies, including, but not limited to, any of the following:

(a) Community mental health services programs.

(b) Local public health departments.

(c) Community health centers.

(d) Other local community agencies that may be relevant to a study on the advantages of the collaborative endeavor.

(2) The department shall report the results and recommendations from the feasibility study by September 20, 2005 to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

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

Third-party payments; revenue recapture project.

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

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

(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.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $1,000,000.00 remaining on September 30, 2005 from pay telephone revenues and 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; interdepartmental plan.

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.

Reports.

Sec. 604. (1) The CMHSPs or specialty prepaid health plans shall provide semiannual 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 semiannually report the information in subsection (1) to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

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

Sec. 605. (1) The department shall not implement any closures or consolidations of state hospitals, centers, or agencies until CMHSPs or specialty prepaid health plans 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 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.

(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 specialty prepaid health plans responsible for providing services for persons previously served by the operations.

Placement in state hospitals and centers; collection of revenue for patient reimbursement.

Sec. 606. The department may collect revenue for patient reimbursement from first- and third-party payers, including Medicaid, 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.

PUBLIC HEALTH ADMINISTRATION

Annual public health consumption advisory for sportfish; posting.

Sec. 650. The department shall communicate the annual public health consumption advisory for sportfish for calendar years 2004 and 2005. The department shall, at a minimum, post the advisory for each calendar year on the Internet and make the information in the advisory available to the clients of the women, infants, and children special supplemental nutrition program.

HEALTH REGULATORY SYSTEMS

Nursing home surveys; notification.

Sec. 701. The department shall provide electronic notification to the state budget office, the fiscal agencies, and the subcommittees on April 30 and October 31 on the initial and follow-up surveys conducted on all nursing homes in this state. The notification shall contain the location of the Internet site where the report is posted. The report shall include all of the following information:

(a) The number of surveys conducted.

(b) The number requiring follow-up surveys.

(c) The number referred to the Michigan public health institute for remediation.

(d) The number of citations per home.

(e) The number of night and weekend complaints filed.

(f) The number of night and weekend responses to complaints conducted by the department.

(g) The average length of time for the department to respond to a complaint filed against a nursing home.

(h) The number and percentage of citations appealed.

(i) The number and percentage of citations overturned and/or modified.

Request for nursing home investigation; duties of department.

Sec. 703. As a condition for receiving the general fund/general purpose appropriations in part 1 for health systems administration, the department shall provide assistance to any person making an oral request for a nursing home investigation in putting his or her request into writing, shall initiate investigations on all written nursing home complaints filed with the department within 15 days of receipt of the complaint, and shall provide a written response to the complainant within 30 days of receipt of the written complaint.

Emergency medical services personnel serving rural areas.

Sec. 704. The department shall continue to work with grantees supported through the appropriation in part 1 for 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 inspection; executive summary.

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

Nursing home inspectors; experience.

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

Nurse scholarship program.

Sec. 707. It is the intent of the legislature that the funds appropriated in part 1 for the nurse scholarship program, established in section 16315 of the public health code, 1978 PA 368, MCL 333.16315, are 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, it is the intent of the legislature that the department and the board of nursing 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; monthly 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.

INFECTIOUS DISEASE CONTROL

AIDS programs; priority for adolescents.

Sec. 801. In the expenditure of funds appropriated in part 1 for AIDS programs, the department and its subcontractors shall ensure that adolescents receive priority for prevention, education, and outreach services.

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

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

AIDS drug assistance program.

Sec. 803. The department shall continue the AIDS drug assistance program maintaining the prior year eligibility criteria and drug formulary. This section is not intended to prohibit the department from providing assistance for improved AIDS treatment medications.

Residents of long-term care; immunizations.

Sec. 804. The department shall require that the tetanus and diphtheria immunization be offered annually at the same time that the influenza immunization is offered to patients 65 years of age or older who are residents of long-term care facilities.

LOCAL HEALTH ADMINISTRATION AND GRANTS

Implementation of MCL 333.17015; reimbursement.

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

Dissolution of arrangement between county and other local health departments; 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, 2004, 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 5% 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.

Lead abatement program; report.

Sec. 903. 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.

Allocations to local public health operations; contractual standards; distributions; report.

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

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

(3) Distributions in subsection (1) shall be made only to counties that maintain local spending in fiscal year 2004-2005 of at least the amount expended in fiscal year 1992-1993 for the services described in subsection (1).

(4) By April 1, 2005, the department shall make available upon request a report to the senate or house of representatives appropriations subcommittee on community health, the senate or house fiscal agency, or 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

Early detection of breast, cervical, prostate, and colorectal cancer; awareness.

Sec. 1001. From the state funds appropriated in part 1, the department shall allocate funds to promote awareness, education, and early detection of breast, cervical, prostate, and colorectal cancer, and provide for other health promotion media activities.

Alzheimer's disease; information and referral services.

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.

Prevention and smoking cessation programs; priority.

Sec. 1006. 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.

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.

Kidney disease prevention.

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, $400,000.00 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 shall 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.

Childhood and adult arthritis program.

Sec. 1020. From the funds appropriated in part 1 for chronic disease prevention, $906,100.00 shall be allocated for a childhood and adult arthritis program.

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 shall be appropriated for the African-American male health initiative.

Parkinson's disease.

Sec. 1029. From the funds appropriated in part 1 for the Michigan Parkinson's foundation, $200,000.00 shall be appropriated for programs related to Parkinson's disease.

FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES

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

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.

MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs.

Sec. 1104. Before April 1, 2005, the department shall submit a report to the house and senate fiscal agencies and the state budget director on planned allocations from the

amounts appropriated in part 1 for local MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs. Using applicable federal definitions, the report shall include information on all of the following:

(a) Funding allocations.

(b) Actual number of women, children, and/or adolescents served and amounts expended for each group for the fiscal year 2003-2004.

Evaluation of agencies; factors.

Sec. 1105. For all programs for which an appropriation is made in part 1, the department shall contract with those local agencies best able to serve clients. Factors to be used by the department in evaluating agencies under this section shall include ability to serve high-risk population groups; ability to 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; federal funds.

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

Abstinence education.

Sec. 1106a. (1) Federal abstinence money expended in part 1 for the purpose of promoting abstinence education shall provide abstinence education to teenagers most likely to engage in high-risk behavior as their primary focus, and may include programs that include 9- to 17-year-olds. Programs funded must meet all of the following guidelines:

(a) Teaches the gains to be realized by abstaining from sexual activity.

(b) Teaches abstinence from sexual activity outside of marriage as the expected standard for all school-age children.

(c) Teaches that abstinence is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other health problems.

(d) Teaches that a monogamous relationship in the context of marriage is the expected standard of human sexual activity.

(e) Teaches that sexual activity outside of marriage is likely to have harmful effects.

(f) Teaches that bearing children out of wedlock is likely to have harmful consequences.

(g) Teaches young people how to avoid sexual advances and how alcohol and drug use increases vulnerability to sexual advances.

(h) Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

(2) Coalitions, organizations, and programs that do not provide contraceptives to minors and demonstrate efforts to include parental involvement as a means of reducing the risk of teens becoming pregnant shall be given priority in the allocations of funds.

(3) Programs and organizations that meet the guidelines of subsection (1) and criteria of subsection (2) shall have the option of receiving all or part of their funds directly from the department of community health.

Prenatal care outreach and service delivery support; limitation.

Sec. 1107. Of the amount appropriated in part 1 for prenatal care outreach and service delivery support, not more than 10% shall be expended for local administration, data processing, and evaluation.

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

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 would provide dental services to the uninsured in an amount that is no less than the amount allocated to that program in fiscal year 1996-1997.

(2) Not later than December 1 of the current fiscal year, the department shall make available upon request a report to the senate or house of representatives appropriations subcommittee on community health or the senate or house of representatives standing committee on health policy the number of individual patients treated, number of procedures performed, and approximate total market value of those procedures through September 30, 2004.

Agencies receiving family planning funds; designation as delegate agencies.

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

Family planning/pregnancy prevention services.

Sec. 1111. The department shall allocate no less than 87% of the funds appropriated in part 1 for family planning local agreements and the pregnancy prevention program for the direct provision of family planning/pregnancy prevention services.

Communities with high infant mortality rates.

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 fetal infant mortality review network.

Sec. 1124. (1) From the funds appropriated in part 1 from the federal maternal and child health block grant, $450,000.00 shall be allocated if additional block grant funds are available for the statewide fetal infant mortality review network.

(2) It is the intent of the legislature that this project shall be funded with a like amount in fiscal year 2005-2006 should federal funds become available.

Migrant health care.

Sec. 1128. The department shall make every effort to maximize the receipt of federal Medicaid funds to support the activities of the migrant health care line item.

Elevated blood lead levels; report on number of children.

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.

Infant mortality rate; release of data.

Sec. 1133. The department shall release infant mortality rate data to all local public health departments no later than 48 hours prior to releasing infant mortality rate data to the public.

School health education.

Sec. 1135. (1) Provision of the school health education curriculum, such as the Michigan model or another comprehensive school health education curriculum, shall be in accordance with the health education goals established by the Michigan model for the comprehensive school health education state steering committee. The state steering committee shall be comprised of a representative from each of the following offices and departments:

(a) The department of education.

(b) The department of community health.

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

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

(e) The family independence agency.

(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.

Child advocacy centers.

Sec. 1136. Contingent on the availability of state funds, funds shall be allocated for child advocacy centers.

WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Farmer's market 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 by April 1, 2005 based on local commitment of funds.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

Children with special health care needs.

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.

Authority of department.

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

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

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

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

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

Children's special health care services program; eligibility; referral.

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

OFFICE OF DRUG CONTROL POLICY

Byrne formula grant program; funding.

Sec. 1250. In addition to the $1,800,000.00 in Byrne formula grant program funding the department provides to local drug treatment courts, the department shall provide $1,800,000.00 in Byrne formula grant program funding to the judiciary by interdepartmental grant.

CRIME VICTIM SERVICES COMMISSION

Forensic nurse examiner programs; expansion.

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

Collection of evidence; procedures.

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

OFFICE OF SERVICES TO THE AGING

Community and nutrition services and home services.

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 list.

Sec. 1403. 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.

Day care, care management, respite care, and other 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.

Sec. 1406. The appropriation of $5,000,000.00 of tobacco settlement 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 10% 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. The legislature supports choice and the right of local counties 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. The legislature supports the office of services to the aging working with others to provide training to commissions 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, including home and community-based waiver services, unless they receive a waiver from the department. 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.

Sec. 1416. The legislature affirms the 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.

MEDICAL SERVICES

Remedial services.

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

Medical services to elderly and disabled persons; income eligibility.

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

Medical coverage; purchase; buy-in; premiums.

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; notice of revisions.

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; 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 related 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.

Cost reports; review; settlements.

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

Medical services recipients with other third-party sources of payment.

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.

Electronic billings.

Sec. 1615. Unless prohibited by federal or state law or regulation, the department shall require enrolled Medicaid providers to submit their billings for services electronically.

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) 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 where a generic equivalent is available, except as prohibited by federal or state law or regulation.

(3) For fee-for-service recipients, an optional mail order pharmacy program shall be implemented.

(4) If a pharmaceutical quality assurance assessment program is established by September 30, 2004 that allows the state to retain $18,900,000.00 of the assessment, the dispensing fee shall remain at fiscal year 2003-2004 levels and the mail order pharmacy program shall not be implemented.

Prospective drug utilization review and disease management systems.

Sec. 1621. (1) The department may implement prospective drug utilization review and disease management systems. The prospective drug utilization review and disease management systems authorized by this subsection shall have physician oversight, shall focus on patient, physician, and pharmacist education, and shall be developed in consultation with the national pharmaceutical council, Michigan state medical society, Michigan association of osteopathic physicians, Michigan pharmacists' association, Michigan health and hospital association, and Michigan nurses' association.

(2) This section does not authorize or allow therapeutic substitution.

Disease management and health management programs; pilot project; use of resulting savings.

Sec. 1621a. (1) The department, in conjunction with pharmaceutical manufacturers or their agents, may establish pilot projects to test the efficacy of disease management and health management programs.

(2) The department may negotiate a plan that uses the savings resulting from the services rendered from these programs, in lieu of requiring a supplemental rebate for the inclusion of those participating parties' products on the department's preferred drug list.

Pharmaceutical best practice initiative.

Sec. 1622. The department shall implement a pharmaceutical best practice initiative. All of the following apply to that initiative:

(a) A physician that calls the department's agent for prior authorization of drugs that are not on the department's preferred drug list shall be informed of the option to speak to the agent's physician on duty concerning the prior authorization request if the agent's pharmacist denies the prior authorization request. If immediate contact with the agent's physician on duty is requested, but cannot be arranged, the physician placing the call shall be immediately informed of the right to request a 72-hour supply of the nonauthorized drug.

(b) The department's prior authorization and appeal process shall be available on the department's website. The department shall also continue to implement a program that allows providers to file prior authorization and appeal requests electronically.

(c) The department shall provide authorization for prescribed drugs that are not on its preferred drug list if the prescribing physician verifies that the drugs are necessary for

the continued stabilization of the patient's medical condition following documented previous failures on earlier prescription regimens. Documentation of previous failures may be provided by telephone, facsimile, or electronic transmission.

(d) Meetings of the department's pharmacy and therapeutics committee shall be open to the public with advance notice of the meeting date, time, place, and agenda posted on the department's website 14 days in advance of each meeting date. By January 31 of each year, the department shall publish the committee's regular meeting schedule for the year on the department's website. The pharmacy and therapeutics committee meetings shall be subject to the requirements of the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. The committee shall provide an opportunity for interested parties to comment at each meeting following written notice to the committee's chairperson of the intent to provide comment.

(e) The pharmacy and therapeutics committee shall make recommendations for the inclusion of medications on the preferred drug list based on sound clinical evidence found in labeling, drug compendia, and peer-reviewed literature pertaining to use of the drug in the relevant population. The committee shall develop a method to receive notification and clinical information about new drugs. The department shall post this process and the necessary forms on the department's website.

(f) The department shall assure compliance with the published Medicaid bulletin implementing the Michigan pharmaceutical best practices initiative program. The department shall also include this information on its website.

(g) By May 15, 2005, the department shall provide a report to the members of the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies identifying the prescribed drugs that are grandfathered in as preferred drugs and available without prior authorization and the population groups to which they apply. The report shall assess strategies to improve the drug prior authorization process.

Pharmacy and therapeutics committee.

Sec. 1622a. (1) It is the intent of the legislature that the pharmacy and therapeutics committee shall consist of the following 11 members:

(a) Five members of the committee shall be Michigan licensed retail pharmacists who are in active clinical practice residing in the state. All member pharmacists shall have a representative portion of fee-for-service Medicaid clients in their practice.

(b) Six members of the committee shall be Michigan licensed physicians who are in active clinical practice residing in the state. All member physicians shall have a representative portion of fee-for-service Medicaid clients in their practice.

(2) It is also the intent of the legislature that the membership on the committee shall be developed by appointing:

(a) Physicians, recommended by the Michigan medical society and the Michigan osteopathic association, and may include at least 1 physician with expertise in mental health.

(b) Retail pharmacists, recommended by the Michigan pharmacists association and the Michigan retailers association, and may include at least 1 pharmacist with expertise with mental health drugs.

Maintenance drugs; 100-day supply.

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.

Multistate drug purchasing compact.

Sec. 1626. Prior to implementing a multistate drug purchasing compact, the department shall provide the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies with a benefit-cost analysis to document that the savings from the compact exceed the savings from the current preferred drug list (PDL) supplemental rebate drug programs.

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, state medical program, children's special health care services, and EPIC.

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

Cost pricing for generic drugs.

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.

Medicaid coverage for podiatric, chiropractic, and hearing aid services.

Sec. 1630. (1) Medicaid coverage for podiatric services and chiropractic services shall be restored 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 shall restore Medicaid coverage for hearing aid services, but 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 services; payment rate increase.

Sec. 1630a. From the funds appropriated in part 1 for auxiliary medical services, the department shall increase payment rates for dental services provided at local public health departments.

Copayments on services.

Sec. 1631. 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.

Healthy kids dental program; expansion.

Sec. 1633. From the funds appropriated in part 1 for auxiliary medical services, the department shall expand the healthy kids dental program statewide if funds become available specifically for expansion of the program.

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.

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, $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 Medicaid matching funds are provided by the universities as allowable state match.

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, 2004.

Eligibility status of Medicaid recipients.

Sec. 1648. The department shall maintain an automated toll-free phone line to enable medical providers to verify the eligibility status of Medicaid recipients. There shall be no charge to providers for the use of the toll-free phone line.

Breast and cervical cancer treatment coverage.

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

Managed care provider; preference; assignment; exception.

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.

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.

Managed care; implementing and contracting by department through HMOs; conditions.

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

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

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

(c) A health plans advisory council is functioning that meets all applicable federal and state requirements for a medical care advisory committee. The council shall review at least quarterly the implementation of the department's managed care plans.

(d) 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.

(e) Enrollment of recipients of children's special health care services in HMOs shall be voluntary during fiscal year 2004-2005.

(f) 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, epilepsy, and other high-cost diseases or conditions and shall implement the case adjustment when it is proven to be actuarially and fiscally sound. Implementation of the case adjustment must be budget neutral.

Services delivered other than through HMO 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.

Lock-in period; exceptions.

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

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

Expedited complaint review procedure.

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

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

(3) Annual reports summarizing the problems and complaints reported and their resolution shall be provided to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, the state budget office, and the department's health plans advisory council.

Hospital emergency room medical services; prior authorization.

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

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

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

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

Hospital access agreement.

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

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

Sections applicable to Medicaid managed care programs.

Sec. 1659. The following sections are the only ones that shall apply to the following Medicaid managed care programs, including the comprehensive plan, children's special

health care services plan, MIChoice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 402, 404, 414, 418, 424, 428, 442, 1650, 1651, 1653, 1654, 1655, 1656, 1657, 1658, 1660, 1661, 1662, and 1699.

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

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

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

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 EPSDT screening and diagnosis service, for any MSS/ISS screening referral, or for up to 3 MSS/ISS service visits.

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

EPSDT and MSS/ISS programs; review by external quality review contractor; analysis and report; training and technical assistance workshop.

Sec. 1662. (1) The department shall require the external quality review contractor to conduct a review of all EPSDT components provided to children from a statistically valid sample of health plan medical records.

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

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

(4) The department shall provide training and technical assistance workshops on EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

MIChild program; eligibility; contracts for services.

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 care coverage for children in families below 150% of the federal poverty level shall be provided through expanded eligibility under the state's Medicaid program. 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 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.

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

(4) 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 line-item appropriations providing for specific health care services.

MIChild program; marketing and outreach.

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

MIChild program eligibility; duration.

Sec. 1672. 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.

Premiums; limitation.

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 exceed $15.00 for a family.

Copayments.

Sec. 1674. The department shall not require copayments under the MIChild program.

Change in eligibility category; beneficiary with serious medical condition.

Sec. 1675. 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.

MIChild program; eligibility; verification.

Sec. 1676. 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.

MIChild program; benefits.

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.

Nursing home employee wage and benefit increases.

Sec. 1680. (1) It is the intent of the legislature that payment increases for enhanced wages and new or enhanced employee benefits provided in previous years through the Medicaid nursing home wage pass-through program be continued in fiscal year 2004-2005.

(2) The department shall provide a report to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies regarding

the amount of nursing home employee wage and benefit increases provided in fiscal year 2003-2004 through the Medicaid nursing home wage pass-through program implemented in previous years.

(3) The department shall not implement any increase or decrease in the Medicaid nursing home wage pass-through program in fiscal year 2004-2005.

Use of family members, friends, and neighbors of home and community-based services participants.

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

Enforcement actions; penalty money.

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

Individuals with terminal or chronic illness; programs.

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.

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.

Sec. 1687. (1) From the funds appropriated in part 1 for long-term care services, the department shall contract with a stand-alone psychiatric facility that provides at least 20% of its total care to Medicaid recipients to provide access to Medicaid recipients who require specialized Alzheimer's disease or dementia care.

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

(2) The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the effectiveness of the contract required under subsection (1) to improve the quality of services to Medicaid recipients.

Medicaid home and community-based waiver; personal care or other services.

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 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 waiver is not a violation of this section.

Medicaid home and community-based programs; enrollment priority; report; competitive bid process for new screening process.

Sec. 1689. (1) Priority in enrolling additional persons in the Medicaid home and community-based services 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 implement 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 program. If there is a net decrease in the number of Medicaid nursing home days of care during the most recent quarter in comparison with the previous quarter and a net cost savings attributable to moving individuals from a nursing home to the home and community-based services waiver program, the department shall transfer the net cost savings to the home and community-based services waiver program. If a transfer is required, it shall be done on a quarterly basis.

(2) Within 30 days of the end of each fiscal quarter, the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies that details existing and future allocations for the home and community-based 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 and the amount of funds transferred.

(3) The department shall utilize a competitive bid process to award funds for the implementation of the new screening process to be applied to home and community-based services and nursing facility services provided by Medicaid.

PACE program.

Sec. 1690. (1) Contingent on the availability of funds and the approval of the centers for Medicaid and Medicare services, the department shall encourage and assist in the establishment of a program of all inclusive care for the elderly (PACE), in at least parts of 3 west Michigan counties, being Kent, Barry, and Ionia.

(2) This program shall provide a capitated, managed care benefit for the frail elderly, provided by a not-for-profit agency, that will feature a comprehensive medical and social service delivery system. In addition, the program shall use a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs. The PACE program may be funded by a combination of Medicaid, Medicare, or other fund sources.

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

Federal Medicaid program; reimbursement for services provided in Michigan schools; agreements to share funds.

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

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

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

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

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

Special adjustor payments; increase.

Sec. 1693. The special adjustor payments appropriation in part 1 may be increased if the department submits a medical services state plan amendment pertaining to this line item at a level higher than the appropriation. The department is authorized to appropriately adjust financing sources in accordance with the increased appropriation.

Children's hospitals with high indigent care volume.

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

Use of funds as state match requirement.

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

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

Hospitals serving indigent patients; hospitals providing graduate medical education training programs; payments.

Sec. 1699. (1) The department may make separate payments directly to qualifying hospitals serving a disproportionate share of indigent patients, 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.

(2) The department shall make GME payments directly to qualifying hospitals. The department shall not make GME payments to qualifying hospitals through HMOs.

Actuarially sound capitation rates; waiver; alternative approaches.

Sec. 1700. (1) The department shall request a waiver of 42 CFR 438.6(c)(1)(i) from the centers for Medicare and Medicaid services to obtain approval to implement actuarially sound capitation rates for managed care organizations over 2 years. If the waiver is denied by the centers for Medicare and Medicaid services, Medicaid providers shall receive a reduction in rates to finance the increase necessary to pay actuarially sound rates to Medicaid HMOs.

(2) The department shall study alternative approaches to providing Medicaid physical health services to clients currently served by Medicaid managed care organizations. This study shall examine the estimated cost of each alternative, the potential changes in the relationships of providers to the Medicaid program, and the potential effects of each alternative on the Medicaid clientele. Results of this study shall be provided to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by January 1, 2005. This study shall consider at least the following alternative approaches:

(a) A continuation of the current managed care program.

(b) A return to coverage on a fee-for-service basis.

(c) Implementation of a primary care case management approach.

(d) Contracting with a single managed care organization that would provide statewide coverage for Medicaid clients.

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

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

Emergency physicians professional services; 2-tier reimbursement methodology.

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 2004-2005, 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.

(3) If federal law, regulation, or judicial ruling finds that this 2-tier reimbursement methodology is not health insurance portability and accountability act (HIPAA) compliant

prior to the end of fiscal year 2003-2004, the department shall immediately provide the chairpersons of the senate and house appropriations subcommittees on community health and their respective fiscal agencies with the proposed modifications necessary to bring this methodology into compliance.

(4) The proposal specified in subsection (3) should be as consistent as possible with the intent of the methodology specified in this section and must be provided to the subcommittee chairpersons and respective fiscal agencies no less than 30 days before the effective date of the proposal.

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.

Participation by dentists in Medicaid program; study.

Sec. 1713. (1) The department, in conjunction with the Michigan dental association, shall undertake a study to determine the level of participation by Michigan licensed dentists in the state's Medicaid program. The study shall identify the distribution of dentists throughout the state, the volume of Medicaid recipients served by each participating dentist, and areas in the state underserved for dental services.

(2) The study described in subsection (1) shall also include an assessment of what factors may be related to the apparent low participation by dentists in the Medicaid program, and the study shall make recommendations as to how these barriers to participation may be reduced or eliminated.

(3) This study shall be provided to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies no later than April 1, 2005.

Hospital case rate.

Sec. 1716. In implementing the hospital case rate under the Medicaid adult benefits waiver, the department shall set the hospital case rate at a level that ensures that the gross savings from the hospital case rate does not exceed $108,592,200.00.

Disproportionate share hospital funding; distribution pool.

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 2003-2004 based on a formula that is weighted proportional to the product of each eligible system's Medicaid revenue and each eligible system's Medicaid utilization.

(2) By November 1, 2004, 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.

Adult home help services; reduction, suspension, termination, or denial.

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 enhance its Medicare recovery program by January 1, 2005.

Return of prepaid funds; review; recommendations.

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, 2005. 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.

Medicaid matching funds.

Sec. 1722. The department is authorized to make a disproportionate share payment to a hospital above the appropriation in part 1 if the necessary Medicaid matching funds are provided by, or on behalf of, the hospital as allowable state match.

Allocations; purposes.

Sec. 1723. Contingent on the availability of state and federal Medicaid funds, $20,000,000.00 shall be allocated for the following purposes:

(a) $15,000,000.00 shall be distributed for a Michigan first alert response program to hospitals in this state that are verified by the American college of surgeons as level I trauma centers. Of this amount, $10,000,000.00 shall be distributed in proportion to each hospital's share of annual uncompensated care costs, and $5,000,000.00 shall be distributed in proportion to each hospital's share of annual emergency room visits.

(b) The remaining $5,000,000.00 of the amount described in this section shall be distributed to hospitals in this state that are located beyond 50 miles from a level I trauma center and have over 14,000 emergency room visits annually. Of this amount, $3,300,000.00 shall be distributed in proportion to each hospital's share of annual uncompensated care costs, and $1,700,000.00 shall be distributed in proportion to each hospital's share of annual emergency room visits.

Treatment of respiratory syncytial virus; reimbursement for purchase of injectable drugs.

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.

This act is ordered to take immediate effect.

Approved September 28, 2004.

Filed with Secretary of State September 29, 2004.

[No. 350]

(SB 1066)

AN ACT to make appropriations for the department of environmental quality for the fiscal year ending September 30, 2005; 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, 2005, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF ENVIRONMENTAL QUALITY		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	1,564.2	
GROSS APPROPRIATION	$	341,649,300
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		14,263,000
ADJUSTED GROSS APPROPRIATION	$	327,386,300
Federal revenues:		
Total federal revenues		133,766,800
Special revenue funds:		
Total local revenues		0
Total private revenues		445,900
Total other state restricted revenues		164,450,800
State general fund/general purpose	$	28,722,800
FUND SOURCE SUMMARY:		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	1,564.2	
GROSS APPROPRIATION	$	341,649,300
Interdepartmental grant revenues:		
IDG-MDA		106,200
IDG-MDCH, local public health operations		10,472,500
IDG-MDSP		672,700
IDG, Michigan transportation fund		958,200
IDT, interdivisional charges		2,053,400
Total interdepartmental grants and intradepartmental transfers		14,263,000
ADJUSTED GROSS APPROPRIATION	$	327,386,300
Federal revenues:		
DHS, federal		225,700
DOC-NOAA, federal		3,194,200
DOD, federal		485,600