[No. 296]

(SB 964)

AN ACT to make appropriations for the department of community health and certain state purposes related to mental health, public health, and medical services for the fiscal year ending September 30, 2001; to provide for the expenditure of those appropriations; to create funds; to require and provide for reports; to prescribe the powers and duties of certain local and state agencies and departments; to provide for disposition of fees and other income received by the various state agencies; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS - FISCAL YEAR 2000-2001

Appropriations; department of community health.

Sec. 101. Subject to the conditions set forth in this act, the amounts listed in this part are appropriated for the department of community health for the fiscal year ending September 30, 2001, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	6,258.1	
Average population	1,528.0	
GROSS APPROPRIATION		$ 8,564,377,900
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		$ 72,087,300
ADJUSTED GROSS APPROPRIATION		$ 8,492,290,600
Federal revenues:		
Total federal revenues		4,461,470,600
Special revenue funds:		
Total local revenues		910,969,100
Total private revenues		49,649,300
Tobacco settlement revenue		86,021,400
Total other state restricted revenues		297,189,000
State general fund/general purpose		$ 2,686,991,200

Departmentwide administration.

Sec. 102. DEPARTMENTWIDE ADMINISTRATION

Full-time equated unclassified positions	6.0	
Full-time equated classified positions	514.7	
Director and other unclassified—6.0 FTE positions		$ 570,100
Community health advisory council		28,900
Departmental administration and management—491.7 FTE positions		55,428,000
Certificate of need program administration—13.0 FTE positions		918,400
Worker's compensation program—1.0 FTE position		11,512,500
Rent and building occupancy		8,715,200

	For Fiscal Year Ending Sept. 30, 2001
Developmental disabilities council and projects—9.0 FTE positions	$ 2,734,200
GROSS APPROPRIATION	$ 79,907,300
Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from the department of treasury, Michigan state hospital finance authority	98,800
Federal revenues:	
Total federal revenues	24,409,600
Special revenue funds:	
Total private revenues	35,900
Total other state restricted revenues	3,559,900
State general fund/general purpose	$ 51,803,100

Mental health/substance abuse services administration and special projects.

Sec. 103. MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Full-time equated classified positions	112.0
Mental health/substance abuse program administration—112.0 FTE positions	$ 10,510,500
Consumer involvement program	314,100
Gambling addiction	3,500,000
Protection and advocacy services support	818,300
Mental health initiatives for older persons	1,615,800
Community residential and support services	5,646,800
Highway safety projects	2,337,200
Federal and other special projects	6,977,200
GROSS APPROPRIATION	$ 31,719,900
Federal revenues:	
Total federal revenues	11,548,100
Special revenue funds:	
Total private revenues	125,000
Total other state restricted revenues	3,682,300
State general fund/general purpose	$ 16,364,500

Community mental health/substance abuse services programs.

Sec. 104. COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Full-time equated classified positions	4.0
Medicaid mental health services	$ 1,182,449,100
Community mental health non-Medicaid services	311,801,500
Multicultural services	3,848,000
Medicaid substance abuse services	24,851,000
Respite services	3,318,600
CMHSP, purchase of state services contracts	166,918,500
Civil service charges	2,606,400
Federal mental health block grant—2.0 FTE positions	10,849,900

		For Fiscal Year Ending Sept. 30, 2001
Pilot projects in prevention for adults and children—2.0 FTE positions	$	994,700
State disability assistance program substance abuse services		6,600,000
Community substance abuse prevention, education and treatment programs		83,740,400
GROSS APPROPRIATION	$	1,797,978,100
Appropriated from:		
Federal revenues:		
Total federal revenues		752,995,800
Special revenue funds:		
Total other state restricted revenues		6,342,400
State general fund/general purpose	$	1,038,639,900

State psychiatric hospitals, centers for persons with developmental disabilities, and forensic and prison mental health services.

Sec. 105. STATE PSYCHIATRIC HOSPITALS, CENTERS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AND FORENSIC AND PRISON MENTAL HEALTH SERVICES

Total average population	1,528.0	
Full-time equated classified positions	4,699.0	
Caro regional mental health center - psychiatric hospital - adult—518.0 FTE positions	$	35,643,500
Average population	200.0	
Kalamazoo psychiatric hospital - adult—376.0 FTE positions		27,080,300
Average population	125.0	
Northville psychiatric hospital - adult—862.0 FTE positions		63,889,500
Average population	385.0	
Walter P. Reuther psychiatric hospital - adult—440.0 FTE positions		34,794,800
Average population	215.0	
Hawthorn center - psychiatric hospital - children and adolescents—330.0 FTE positions		23,098,800
Average population	118.0	
Mount Pleasant center - developmental disabilities—472.0 FTE positions		29,878,000
Average population	195.0	
Southgate center - developmental disabilities—228.0 FTE positions		15,589,900
Average population	80.0	
Center for forensic psychiatry—522.0 FTE positions		39,151,000
Average population	210.0	
Forensic mental health services provided to the department of corrections—938.0 FTE positions		71,380,700
Revenue recapture		750,000
IDEA, federal special education		92,000
Special maintenance and equipment		879,000
Purchase of medical services for residents of hospitals and centers		1,700,000

		For Fiscal Year Ending Sept. 30, 2001
Closed site, transition, and related costs—13.0 FTE positions	$	510,300
Severance pay		896,000
Gifts and bequests for patient living and treatment environment		2,000,000
GROSS APPROPRIATION	$	347,333,800
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of corrections		71,380,700
Federal revenues:		
Total federal revenues		32,934,200
Special revenue funds:		
CMHSP, purchase of state services contracts		166,918,500
Other local revenues		16,596,400
Total private revenues		2,000,000
Total other state restricted revenues		16,473,100
State general fund/general purpose	$	41,030,900

Public health administration.

Sec. 106. PUBLIC HEALTH ADMINISTRATION

Full-time equated classified positions	88.3	
Executive administration—15.5 FTE positions	$	1,367,100
Minority health grants and contracts		650,000
Vital records and health statistics—72.8 FTE positions		6,167,700
GROSS APPROPRIATION	$	8,184,800
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from family independence agency		137,800
Federal revenues:		
Total federal revenues		2,809,800
Special revenue funds:		
Total other state restricted revenues		2,036,600
State general fund/general purpose	$	3,200,600

Infectious disease control.

Sec. 107. INFECTIOUS DISEASE CONTROL

Full-time equated classified positions	44.3	
AIDS prevention, testing and care programs—9.8 FTE positions	$	22,218,400
Immunization local agreements		14,190,300
Immunization program management and field support—7.7 FTE positions		1,698,900
Sexually transmitted disease control local agreements		2,460,700
Sexually transmitted disease control management and field support—26.8 FTE positions		2,825,800
GROSS APPROPRIATION	$	43,394,100
Appropriated from:		
Federal revenues:		
Total federal revenues		29,300,600

		For Fiscal Year Ending Sept. 30, 2001
Special revenue funds:		
Total private revenues	$	1,155,000
Total other state restricted revenues		6,937,700
State general fund/general purpose	$	6,000,800

Laboratory services.

Sec. 108. LABORATORY SERVICES

Full-time equated classified positions....118.2		
Laboratory services—118.2 FTE positions	$	12,566,100
Lyme disease grant		75,000
GROSS APPROPRIATION	$	12,641,100
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from environmental quality		389,400
Federal revenues:		
Total federal revenues		2,028,000
Special revenue funds:		
Total other state restricted revenues		3,607,400
State general fund/general purpose	$	6,616,300

Epidemiology.

Sec. 109. EPIDEMIOLOGY

Full-time equated classified positions....31.5		
AIDS surveillance and prevention program—7.0 FTE positions	$	1,772,800
Epidemiology administration—24.5 FTE positions		5,080,900
Tuberculosis control and recalcitrant AIDS program		498,300
GROSS APPROPRIATION	$	7,352,000
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of environmental quality		80,600
Federal revenues:		
Total federal revenues		4,679,100
Special revenue funds:		
Total other state restricted revenues		231,000
State general fund/general purpose	$	2,361,300

Local health administration and grants.

Sec. 110. LOCAL HEALTH ADMINISTRATION AND GRANTS

Full-time equated classified positions....3.0		
Implementation of 1993 PA 133, MCL 333.17015	$	100,000
Lead abatement program—3.0 FTE positions		2,835,500
Local health services		512,300
Local public health operations		41,070,200
Medical services cost reimbursement to local health departments		1,800,000
Special populations health care		620,600
GROSS APPROPRIATION	$	46,938,600

		For Fiscal Year Ending Sept. 30, 2001
Appropriated from:		
Federal revenues:		
Total federal revenues	$	3,791,000
Special revenue funds:		
Total other state restricted revenues		1,243,500
State general fund/general purpose	$	41,904,100

Chronic disease and injury prevention and health promotion.

Sec. 111. CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Full-time equated classified positions....33.7		
AIDS and risk reduction clearinghouse and media campaign	$	1,982,200
Alzheimer's information network		440,000
Cancer prevention and control program—13.6 FTE positions		12,505,100
Chronic disease prevention		3,103,400
Diabetes program—9.0 FTE positions		4,197,200
Early childhood collaborative secondary prevention		1,750,000
Employee wellness program grants (includes $50.00 per diem and expenses for the risk reduction and AIDS policy commission)		6,259,300
Health education, promotion, and research programs—2.9 FTE positions		1,318,100
Injury control intervention project		1,052,800
Michigan Parkinson's foundation		200,000
Morris J. Hood Wayne State University diabetes outreach		500,000
Physical fitness, nutrition, and health		1,250,000
Public health traffic safety coordination		415,000
School health and education programs		2,182,800
Smoking prevention program—6.2 FTE positions		7,263,800
Tobacco tax collection and enforcement		810,000
Violence prevention—2.0 FTE positions		3,235,500
GROSS APPROPRIATION	$	48,465,200
Appropriated from:		
Federal revenues:		
Total federal revenues		12,237,300
Special revenue funds:		
Total other state restricted revenues		32,245,100
State general fund/general purpose	$	3,982,800

Community living, children, and families.

Sec. 112. COMMUNITY LIVING, CHILDREN, AND FAMILIES

Full-time equated classified positions....88.8		
Adolescent health care services	$	3,742,300
Childhood lead program—5.0 FTE positions		1,397,800
Children's waiver home care program		22,365,100
Community living, children, and families administration—73.3 FTE positions		7,658,600

		For Fiscal Year Ending Sept. 30, 2001
Dental programs	$	510,400
Dental program for persons with developmental disabilities		151,000
Family planning local agreements		8,100,000
Family support subsidy		14,276,700
Housing and support services—1.0 FTE position		4,830,900
Local MCH services		9,050,200
Medicaid outreach and service delivery support		8,488,600
Migrant health care		166,100
Newborn screening follow-up and treatment services		2,123,400
Omnibus reconciliation act implementation—9.0 FTE positions		12,757,000
Pediatric AIDS prevention and control		985,300
Pregnancy prevention program		7,196,100
Prenatal care outreach and service delivery support		4,299,300
Southwest community partnership		2,247,300
Special projects—0.5 FTE position		4,726,600
Sudden infant death syndrome program		321,300
GROSS APPROPRIATION	$	115,394,000
Appropriated from:		
Federal revenues:		
Total federal revenues		71,588,500
Special revenue funds:		
Total private revenues		261,100
Total other state restricted revenues		8,574,200
State general fund/general purpose	$	34,970,200

Women, infants, and children food and nutrition programs.

Sec. 113. WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAMS

Full-time equated classified positions	42.0	
Women, infants, and children program administration and special projects—42.0 FTE positions	$	5,017,100
Women, infants, and children program local agreements and food costs		156,882,400
GROSS APPROPRIATION	$	161,899,500
Appropriated from:		
Federal revenues:		
Total federal revenues		117,452,200
Special revenue funds:		
Total private revenues		44,447,300
State general fund/general purpose	$	0

Children's special health care services.

Sec. 114. CHILDREN'S SPECIAL HEALTH CARE SERVICES

Full-time equated classified positions	66.6	
Children's special health care services administration—66.6 FTE positions	$	5,434,400
Amputee program		184,600
Bequests for care and services		1,329,600

		For Fiscal Year Ending Sept. 30, 2001
Case management services	$	3,923,500
Conveyor contract		559,100
Medical care and treatment		130,005,400
GROSS APPROPRIATION	$	141,436,600
Appropriated from:		
Federal revenues:		
Total federal revenues		66,177,100
Special revenue funds:		
Private - bequests		900,000
Total other state restricted revenues		4,048,500
State general fund/general purpose	$	70,311,000

Office of drug control policy.

Sec. 115. OFFICE OF DRUG CONTROL POLICY

Full-time equated classified positions	17.0	
Drug control policy—17.0 FTE positions	$	1,933,700
Anti-drug abuse grants		25,841,700
GROSS APPROPRIATION	$	27,775,400
Appropriated from:		
Federal revenues:		
Total federal revenues		27,395,800
State general fund/general purpose	$	379,600

Crime victim services commission.

Sec. 116. CRIME VICTIM SERVICES COMMISSION

Full-time equated classified positions	9.0	
Grants administration services—9.0 FTE positions	$	1,033,800
Justice assistance grants		15,000,000
Crime victim rights services grants		7,955,300
GROSS APPROPRIATION	$	23,989,100
Appropriated from:		
Federal revenues:		
Total federal revenues		15,840,200
Special revenue funds:		
Total other state restricted revenues		7,641,200
State general fund/general purpose	$	507,700

Office of services to the aging.

Sec. 117. OFFICE OF SERVICES TO THE AGING

Full-time equated classified positions	40.5	
Commission (per diem $50.00)	$	10,500
Long-term care advisor—3.0 FTE positions		3,021,400
Office of services to aging administration—37.5 FTE positions		4,070,300
Community services		28,907,900
Nutrition services		28,248,000
Senior volunteer services		6,000,000
Senior citizen centers staffing and equipment		2,140,700
Employment assistance		2,748,000

		For Fiscal Year Ending Sept. 30, 2001
DAG commodity supplement	$	7,200,000
Michigan pharmaceutical program		1,500,000
Respite care program		7,100,000
Senior Olympics		100,000
GROSS APPROPRIATION	$	91,046,800
Appropriated from:		
Federal revenues:		
Total federal revenues		40,954,200
Special revenue funds:		
Total private revenues		125,000
Tobacco settlement revenue		8,021,400
Total other state restricted revenues		5,200,000
State general fund/general purpose	$	36,746,200

Medical services administration.

Sec. 118. MEDICAL SERVICES ADMINISTRATION

Full-time equated classified positions	345.5	
Medical services administration—343.7 FTE positions	$	49,718,200
Data processing contractual services		100
Facility inspection contract - state police		132,800
MIChild administration		3,327,800
Michigan essential health care provider		1,229,100
Palliative and hospice care		525,000
Primary care services—1.8 FTE positions		3,700,000
GROSS APPROPRIATION	$	58,633,000
Appropriated from:		
Federal revenues:		
Total federal revenues		36,730,800
Special revenue funds:		
Total private revenues		100,000
Total other state restricted revenues		1,172,100
State general fund/general purpose	$	20,630,100

Medical services.

Sec. 119. MEDICAL SERVICES

Hospital services and therapy	$	713,289,700
Hospital disproportionate share payments		45,000,000
Physician services		152,533,000
Medicare premium payments		129,574,000
Pharmaceutical services		387,680,300
Home health services		28,184,000
Transportation		6,571,100
Auxiliary medical services		78,217,700
Long-term care services		1,212,792,000
Elder prescription insurance coverage		37,500,700
Health plan services		1,333,561,300
MIChild outreach		3,327,800
MIChild program		57,567,100

		For Fiscal Year Ending Sept. 30, 2001
Personal care services	$	30,329,400
Maternal and child health		9,234,500
Adult home help		158,781,400
Social services to the physically disabled		1,344,900
Subtotal basic medical services program		4,385,488,900
Wayne County medical program		44,012,800
School-based services		142,782,300
State and local medical programs		56,724,200
Special adjustor payments		891,280,400
Subtotal special medical services payments		1,134,799,700
GROSS APPROPRIATION	$	5,520,288,600
Appropriated from:		
Federal revenues:		
Total federal revenues		3,208,598,300
Special revenue funds:		
Total local revenues		727,454,200
Total private revenues		500,000
Tobacco settlement revenue		78,000,000
Total other state restricted revenues		194,194,000
State general fund/general purpose	$	1,311,542,100

PART 2

PROVISIONS CONCERNING APPROPRIATIONS FOR FISCAL YEAR 2000-2001

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 2000-2001 is $3,070,201,600.00 and state spending from state resources to be paid to local units of government for fiscal year 2000-2001 is $1,027,454,000.00. 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	$	2,000,000
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS		
Mental health initiatives for older persons		1,165,800
COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS		
Pilot projects in prevention for adults and children		913,200
State disability assistance program substance abuse services		6,600,000

Community substance abuse prevention, education, and treatment programs	$	18,673,500
Medicaid mental health services		517,871,100
Community mental health non-Medicaid services		311,801,500
Multicultural services		3,848,000
Medicaid substance abuse services		10,890,000
Respite services		3,318,600
INFECTIOUS DISEASE CONTROL		
AIDS prevention, testing, and care programs		1,466,800
Sexually transmitted disease local agreements		452,900
LOCAL HEALTH ADMINISTRATION AND GRANTS		
Special populations health care		29,600
Local public health operations		41,070,200
CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION		
Cancer prevention and control program		397,000
Diabetes program		1,275,000
Employee wellness programs		1,545,100
School health and education programs		2,000,000
Smoking prevention program		2,880,000
COMMUNITY LIVING, CHILDREN, AND FAMILIES		
Adolescent health care services		1,908,000
Family planning local agreements		1,230,300
Homelessness formula grant program - state match		708,800
Local MCH services		246,100
OBRA implementation		2,459,100
Pregnancy prevention program		2,511,800
Prenatal care outreach and service delivery support		1,250,000
CHILDREN'S SPECIAL HEALTH CARE SERVICES		
Case management services		1,433,200
MEDICAL SERVICES		
Special adjustor payments		1,383,800
Hospital disproportionate share payments		18,000,000
Hospital services and therapy		17,559,300
Physician services		5,305,100
Pharmaceutical services		7,265,000
Home health services		1,195,200
Transportation		184,500
OFFICE OF SERVICES TO THE AGING		
Community services		13,681,400
Nutrition services		12,363,000
Senior volunteer services		3,845,400
Michigan pharmaceutical program		140,000
Respite care program		2,000,000

CRIME VICTIM SERVICES COMMISSION		
Crime victim rights services grants	$	4,585,700
TOTAL OF PAYMENTS TO LOCAL UNITS OF GOVERNMENT	$	1,027,454,000

Appropriations subject to §§ 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) "ACCESS" means Arab community center for economic and social services.

(b) "AIDS" means acquired immunodeficiency syndrome.

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

(d) "DAG" means the United States department of agriculture.

(e) "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.

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

(g) "DSH" means disproportionate share hospital.

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

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

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

(k) "GME" means graduate medical education.

(*l*) "HIV" means human immunodeficiency virus.

(m) "HMO" means health maintenance organization.

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

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

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

(q) "OBRA" means the omnibus budget reconciliation act of 1987, Public Law 100-203, 101 Stat. 1330.

(r) "Qualified 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.

(s) "Title XVIII" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

(t) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v.

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

Billing by department of civil service.

Sec. 204. The department of civil service shall bill departments and agencies 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) Beginning October 1, a hiring freeze is imposed on the state classified civil service. State departments and agencies are prohibited from hiring any new full-time 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 or to positions that are funded with 80% or more federal or restricted funds.

(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. The state budget director shall report by the fifteenth of each month 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 month and the justification for the exception.

Contingency funds; availability for expenditure.

Sec. 206. (1) In addition to the funds appropriated in part 1, there is appropriated an amount not to exceed $100,000,000.00 for federal contingency funds. These funds are not available for expenditure until they have been transferred to another line item in this act under section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

(2) In addition to the funds appropriated in part 1, there is appropriated an amount not to exceed $20,000,000.00 for state restricted contingency funds. These funds are not available for expenditure until they have been transferred to another line item in this act under section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

(3) In addition to the funds appropriated in part 1, there is appropriated an amount not to exceed $20,000,000.00 for local contingency funds. These funds are not available for expenditure until they have been transferred to another line item in this act under section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

(4) In addition to the funds appropriated in part 1, there is appropriated an amount not to exceed $10,000,000.00 for private contingency funds. These funds are not available for expenditure until they have been transferred to another line item in this act under section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

Privatization; project plan.

Sec. 207. At least 60 days before beginning any effort to privatize, the department shall submit a complete project plan to the appropriate senate and house of representatives appropriations subcommittees and the senate and house fiscal agencies. The plan shall include the criteria under which the privatization initiative will be evaluated. The evaluation shall be completed and submitted to the appropriate senate and house of representatives appropriations subcommittees and the senate and house fiscal agencies within 30 months.

Transmission of reports via electronic mail; use of Internet.

Sec. 208. The department shall continue to pilot the use of the internet to fulfill the reporting requirements of this act. This 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 legislative intranet site. The senate and house of representatives appropriations subcommittees and senate and house fiscal agencies shall be notified in writing of the internet or intranet site of any such report. Quarterly, the department shall provide a cumulative listing of the reports submitted during the most recent 3-month period along with the internet or intranet site of each report, and a list of those reports expected to be transmitted in the following quarter.

Purchase of foreign goods or services.

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

Businesses in deprived and depressed communities; contracts to provide services or supplies.

Sec. 210. (1) The director shall take all reasonable steps to ensure businesses in deprived and depressed communities compete for and perform contracts to provide services or supplies, or both. The director shall strongly encourage firms with which the department contracts to subcontract with certified businesses in depressed and deprived communities for services, supplies, or both.

(2) The director shall take all reasonable steps to ensure equal opportunity for all who compete for and perform contracts to provide services or supplies, or both, for the department. The director shall strongly encourage firms with which the department contracts to provide equal opportunity for subcontractors to provide services or supplies, or both.

Carrying forward excess fees and collections revenue.

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.

Amounts supported with 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.

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	$	20,977,000.
(b) Preventive health and health services block grant		6,347,100.
(c) Substance abuse block grant		61,371,200.
(d) Healthy Michigan fund		43,367,500.
(e) Michigan health initiative		9,900,800.

(2) On or before February 1, 2001, 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 2001-02 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 2001-02 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.

Report from departments, agencies, and commissions receiving tobacco tax funds.

Sec. 213. The state departments, agencies, and commissions receiving tobacco tax funds from part 1 shall report by November 1, 2000, 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) Allocations from funds appropriated under these sections.

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

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

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

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

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.

Write-offs of accounts receivable, deferrals, and prior year obligations.

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 2000-2001, but shall also include reimbursements, refunds, adjustments, and settlements from prior years.

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

Medicaid managed mental health care program.

Sec. 217. 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 to support the Medicaid managed mental health care program in that month. The information shall include the total paid to each CMHSP, per

capita rate paid for each eligibility group for each CMHSP, and number of cases in each eligibility group for each CMHSP, and year-to-date summary of eligibles and expenditures for the Medicaid managed mental health care program.

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 7 conditions listed in section 5431(1)(a) through (g) of the public health code, 1978 PA 368, MCL 333.5431, community health annex of the Michigan emergency management plan, and prenatal care.

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, 2000, and May 1, 2001, 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, 2001, 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.

Contracts with Michigan public health institute; 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; collection of 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.

DEPARTMENTWIDE ADMINISTRATION

Employees returning to work under limited duty assignments.

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.

Community health advisory council; per diems.

Sec. 302. Funds appropriated in part 1 for the community health advisory council may be used for member per diems of $50.00 and other council expenditures.

First-party payment; requirement prohibited.

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

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Occupancy in community living arrangement; contract to provide legal services.

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 board to provide services to persons with mental illness or developmental disability.

Adolescent suicide and preventative resources; survey; assessment.

Sec. 352. From the funds appropriated, the department shall conduct a statewide survey of adolescent suicide and assessment of available preventative resources.

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Community mental health services; authority and responsibility of local CMHSP; single entry and exit; alteration or modification of contract.

Sec. 401. (1) 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. The department shall ensure that each board 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 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.

(2) In partnership with CMHSPs, the department shall establish a process to ensure the long-term viability of a single entry and exit and locally controlled community mental health system.

(3) A contract between a CMHSP and the department shall not be altered or modified without a prior written agreement of the parties to the contract.

Final authorizations to CMHSPs; contracts; report; information.

Sec. 402. (1) From funds appropriated in part 1, final authorizations to CMHSPs shall be made upon the execution of contracts between the department and CMHSPs. 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 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 entered into under this subsection for fiscal year 2000-2001 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 that would affect rates or expenditures are enacted.

(b) Any amendments to contracts with CMHSPs 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 with multicultural services providers.

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

Community mental health services programs; report; data reporting requirements; data as complete and consistent.

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 which shall include information required by this section.

(2) The report shall contain information for each community mental health services board and a statewide summary, each of which shall include at least the following information:

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

(b) Per capita expenditures by client population group.

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

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

(e) Information about access to community mental health services programs which shall include but not be limited to both of 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.

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

(g) An analysis of information provided by community mental health 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.

(h) An estimate of the number of FTEs employed by the CMHSPs or contracted with directly by the CMHSPs as of September 30, 2000 and an estimate of the number of FTEs employed through contracts with provider organizations as of September 30, 2000.

(i) Lapses and carryforwards during fiscal year 1999-2000 for CMHSPs.

(j) Contracts for mental health services entered into by CMHSPs with providers, including amounts and rates, organized by type of service provided.

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

(*i*) Expenditures by each CMHSP 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.

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

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

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

Sec. 405. It is the intent of the legislature that the employee wage pass-through funded 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 that was funded beginning April 1, 1999 shall continue to be paid to direct care workers in fiscal year 2000-2001.

State disability assistance substance abuse services program; room and board payments in substance abuse residential facilities; reimbursement.

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.

Coordinating agencies and designated service providers; contracting; 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 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; required data as complete and consistent.

Sec. 408. (1) By April 15, 2001, the department shall report the following data from fiscal year 1999-2000 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.

Priority to service providers furnishing child care services.

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

Substance abuse treatment 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.

Jail diversion services.

Sec. 411. (1) The department shall ensure that each contract with a CMHSP requires the CMHSP 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 shall have jail diversion services and shall work toward establishing working relationships with representative staff of local law enforcement agencies. Such agencies include the 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.

Non-Medicaid substance abuse services; contract with 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.

Competitive bid process; plan; pilot program.

Sec. 413. In fiscal year 2000-2001, the department shall develop a plan that conforms to the requirements of the health care finance administration for competitive procurement of contracts to manage Medicaid mental health, developmental disabilities, and substance abuse services. The department shall submit the plan to the appropriations subcommittees for community health of both the house of representatives and senate and to the health care financing administration. The plan shall continue a carve-out for specialty services for persons with developmental disabilities and mental illness and requiring substance abuse services. If the health care financing administration approves the plan, the department may implement a competitive bid pilot program that complies with the approved plan. In fiscal year 2000-2001, the department shall not implement a statewide competitive bid process.

Managed care plan for specialized substance abuse services.

Sec. 414. Medicaid substance abuse treatment services shall be managed by selected CMHSPs pursuant to the health care financing administration's approval of Michigan's 1915(b) waiver request to implement a managed care plan for specialized substance abuse services. The selected CMHSPs 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 shall be responsible for the reimbursement of claims for specialized substance abuse services. The CMHSPs 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.

Cost of prescribed psychotropic medications; liability of community mental health boards; lapses; reports; transfer to offset excess expenditures.

Sec. 416. (1) Of the funds appropriated in part 1 for pharmaceutical services, community mental health boards shall not be held liable for the cost of prescribed psychotropic medications during fiscal year 2000-2001.

(2) In calculating the available amount of lapses for use in offsetting overexpenditures resulting from the implementation of this section, those lapses credited to community mental health line items shall only include appropriation lapses in excess of the amount calculated for the 5% carryforward defined in state statute.

(3) The department shall provide quarterly reports to the senate and house of representatives appropriations subcommittees on community health, their respective fiscal agencies, and community mental health boards that include data on psychotropic medications regarding the type, number, cost and prescribing patterns of Medicaid providers.

(4) Should expenditures for Medicaid mental health services exceed the appropriations contemplated in part 1 due to an increase in the number or mix of Medicaid eligibles, the department shall recommend the transfer of appropriation lapses as may be necessary to offset such expenditures.

Regional partnerships; pilot projects; purpose; basis; retention of net lapses; reports.

Sec. 417. (1) It is the intent of the legislature that the department support pilot projects by community mental health boards to establish regional partnerships.

(2) The purpose of the regional partnerships should be to expand consumer choice, promote service integration, and produce system efficiencies through the coordination of efforts, or other outcomes, as may be determined by participating community mental health boards.

(3) The pilot projects described in this section shall be completely voluntary and be based on projects proposed by the community mental health boards. Each proposed pilot project shall be consistent with the scope, duration, risks, and inducements contained in the plan for competitive procurement that the department submits to the health care financing administration as part of the renewal request for the section 1915(b) managed specialty services waiver.

(4) As an additional incentive for community mental health boards to engage in the pilot projects described in this section, any regional partnership so formed shall be able to retain 100% of any net lapses generated by the regional partnership.

(5) The department shall provide quarterly reports to the senate and house of representatives appropriations subcommittees and their respective fiscal agencies, as to any activities by community mental health boards to form regional partnerships under this section.

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

Third-party payments; priority; manner of collection; revenue recapture project.

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

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

Gifts and bequests for patient living and treatment environments; purpose; use.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $2,000,000.00 remaining on September 30, 2001 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.

Semiannual reports.

Sec. 604. (1) The CMHSPs 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 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 1943 PA 240, MCL 38.19, the department shall provide a closure plan to the house of representatives and senate appropriations subcommittees.

(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 responsible for providing services for persons previously served by the operations.

PUBLIC HEALTH ADMINISTRATION

Vital records and health systems; availability of funds.

Sec. 703. The availability of $200,000.00 for vital records and health systems is contingent upon the enactment of legislation that amends section 2891 of the public health code, 1978 PA 368, MCL 333.2891, to increase fees for vital records services in an amount sufficient to produce $200,000.00 in fee revenue anticipated to be received annually, and that fee increase taking effect.

INFECTIOUS DISEASE CONTROL

Prevention, education, and outreach services; priority to 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 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; maintenance of eligibility criteria and drug formulary.

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.

EPIDEMIOLOGY

Behavioral risk factor survey project; allocation.

Sec. 850. From the funds appropriated in part 1 for epidemiology administration, no less than $150,000.00 shall be allocated for the behavioral risk factor survey project.

LOCAL HEALTH ADMINISTRATION AND GRANTS

Implementation of § 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(15) of the public health code, 1978 PA 368, MCL 333.17015.

Participation of county with other local health department; dissolution of arrangement by county; 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, 2000, the department shall have the authority to assess a penalty from the local health department's administrative accounts in an amount equal to no more than 3% 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 semiannually to the house of representatives and senate appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the expenditures and activities undertaken by the lead abatement program. The report shall include, but is not limited to, a funding allocation schedule, expenditures by category of expenditure and by subcontractor, revenues received, description of program elements, and description of program accomplishments and progress.

Local public health operations; allocations; contractual standards; distributions; report; full expenditure.

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 under contract 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 2000-2001 of at least the amount expended in fiscal year 1992-1993 for the services described in subsection (1).

(4) By April 1, 2001, 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 planned allocation of the funds appropriated for local public health operations.

(5) It is the intent of the legislature that this appropriation be fully expended in fiscal year 2000-2001.

Pollution in Clinton river watershed; sources and responsibility.

Sec. 906. From the funds appropriated in part 1 for local health services, the department shall allocate $50,000.00 for a study to identify the sources of pollution and those responsible for polluting, in the Clinton river watershed.

Lead hazard remediation revolving loan fund program.

Sec. 907. (1) It is the intent of the legislature that the department establish a lead hazard remediation revolving loan fund program. From the funds appropriated in part 1, $1,000,000.00 shall be allocated to the lead hazard remediation revolving loan fund. It is the intent of the legislature that annual appropriations be made to the lead hazard remediation revolving loan fund until cumulative appropriations to the loan fund total a minimum of $5,000,000.00.

(2) The lead hazard remediation revolving loan fund program shall make loans available to qualified low-income families who live in owner-occupied houses in Michigan for the purpose of financing lead hazard remediation and abatement to the homes in which they reside. Families who meet qualifications for federal housing and urban development lead abatement funds are not eligible for this loan program. A home that houses a child with elevated blood lead levels, as defined in section 5456 of the public health code, 1978 PA 368, MCL 333.5456, or that may in the future be occupied by a family with small children, may be eligible for the loan fund program. The loans shall be offered at an interest rate of 2%. The program may be jointly administered by the department and the Michigan state housing development authority.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Awareness, education, and early detection of breast, cervical, prostate, and colorectal cancer; promotion.

Sec. 1001. (1) 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.

(2) The department shall increase funds allocated to promote awareness, education, and early detection of breast, cervical, and prostate cancer by $750,000.00 above the amount allocated for this purpose in fiscal year 1996-1997, and by $150,000.00 for colorectal cancer.

School health and education programs; state steering committee; parent or pupil examination of curriculum content, textbooks, and materials.

Sec. 1002. (1) The amount appropriated in part 1 for school health and education programs shall be allocated in fiscal year 2000-2001 to provide grants to or contract with certain districts and intermediate districts for the provision of a school health education curriculum. Provision of the 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 public health agency in the department of community health.

(d) The office of 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.

Alzheimer's information network; 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.

Hurley and Harper hospitals' prostate cancer demonstration projects.

Sec. 1004. From the amounts appropriated in part 1 for the cancer prevention and control program, the department may allocate funds to the Hurley and Harper hospitals' prostate cancer demonstration projects in fiscal year 2000-2001.

Michigan physical fitness and sports foundation.

Sec. 1005. From the funds appropriated in part 1 for physical fitness, nutrition, and health, up to $1,000,000.00 may be allocated to the Michigan physical fitness and sports foundation. The allocation to the Michigan physical fitness and sports foundation is contingent upon the foundation providing at least a 20% cash match.

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; grants; local school districts as recipients.

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.

Cancer prevention and control program; allocations.

Sec. 1008. From the amount appropriated in part 1 for the cancer prevention and control program, funds shall be allocated to the Karmanos cancer institute/Wayne State University, to the University of Michigan comprehensive cancer center, and to Michigan State University for cancer prevention activities, consistent with the current priorities of the Michigan cancer consortium.

Kidney disease prevention programming.

Sec. 1009. From the funds appropriated in part 1 for the diabetes 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 program.

Sec. 1010. Of the funds appropriated in part 1 for the health education, promotion, and research programs, the department shall allocate $400,000.00 to implement the osteoporosis prevention and treatment education program targeting women and school health education. As part of the program, the department shall design and implement strategies for raising public awareness on the causes and nature of osteoporosis, personal risk factors, value of prevention and early detection, and options for diagnosing and treating osteoporosis.

Improving health of African-American men; report.

Sec. 1011. (1) From the funds appropriated in part 1 for the diabetes program, $320,000.00 shall be allocated for improving the health of African-American men in Michigan. The funds shall be used for screening and patient self-care activities for diabetes, hypertension, stroke, and glaucoma and other eye diseases.

(2) By March 1, 2001, the department shall provide a report on the program under this section to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director.

Early childhood collaborative secondary prevention program.

Sec. 1012. In implementing the early childhood collaborative secondary prevention program, the department shall work cooperatively with the department of education and the family independence agency to address issues and coordinate activities for community-based collaborative prevention services. The department shall report annually on the outcomes of this collaborative effort to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies.

Michigan Parkinson's initiative.

Sec. 1013. The funds appropriated in part 1 for the Michigan Parkinson's Foundation shall be used for implementation of the Michigan Parkinson's Initiative which supports and educates persons with Parkinson's disease and their families. Members of the Michigan Parkinson's Initiative include the University of Michigan, Michigan State University, Wayne State University, Beaumont Hospital, St. John's Hospital and Health Center, Henry Ford Health System, and other organizations as appropriate.

Obesity prevention and education services.

Sec. 1018. From the funds appropriated in part 1 for chronic disease prevention, $500,000.00 shall be allocated for obesity prevention and education services. The department shall use these funds for prevention and education services only, and not for administrative purposes.

Stroke prevention, education, and outreach; allocation; objectives.

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.

Children's arthritis program.

Sec. 1020. From the funds appropriated in part 1 for chronic disease prevention, $50,000.00 shall be allocated for a children's arthritis program.

Women's cardiovascular health program.

Sec. 1021. From the funds appropriated in part 1 for chronic disease prevention, $1,086,000.00 shall be allocated as 1-time funding for a women's cardiovascular health program. The availability of the funds is contingent upon final settlement and receipt of the funds as the result of a final court judgment.

Sec. 1022. From the funds appropriated in part 1 for the smoking prevention program, $1,500,000.00 shall be allocated as 1-time funding to enable eligible state and local municipalities to apply for American legacy foundation grants which are intended to decrease and prevent tobacco consumption among all ages and populations.

COMMUNITY LIVING, CHILDREN, AND FAMILIES

Distribution of funds to local public and private agencies; basis; review.

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; early and periodic screening, diagnosis, and treatment program; 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.

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

Adolescent health care services; recommendations by local advisory committee; report.

Sec. 1102. (1) Agencies receiving funds appropriated from part 1 for adolescent health care services shall do all of the following:

(a) Require each adolescent health clinic funded by the agency to report to the department on an annual basis all of the following information:

(*i*) Funding sources of the adolescent health clinic.

(*ii*) Demographic information of populations served including sex, age, and race. Reporting and presentation of demographic data by age shall include the range of ages of 0-17 years and the range of ages of 18-23 years.

(*iii*) Utilization data that reflects the number of visits and repeat visits and types of services provided per visit.

(*iv*) Types and number of referrals to other health care agencies.

(b) As a condition of the contract, a contract shall include the establishment of a local advisory committee before the planning phase of an adolescent health clinic intended to provide services within that school district. The advisory committee shall be comprised of not less than 50% residents of the local school district, and shall not be comprised of more than 50% health care providers. A person who is employed by the sponsoring agency shall not have voting privileges as a member of the advisory committee.

(c) Not allow an adolescent health clinic funded by the agency, as part of the services offered, to provide abortion counseling or services or make referrals for abortion services.

(d) Require each adolescent health clinic funded by the agency to have a written policy on parental consent, developed by the local advisory committee and submitted to the local school board for approval if the services are provided in a public school building where instruction is provided in grades kindergarten through 12.

(2) A local advisory committee established under subsection (1)(b), in cooperation with the sponsoring agency, shall submit written recommendations regarding the implementation and types of services rendered by an adolescent health clinic to the local school board for approval of adolescent health services rendered in a public school building where instruction is provided in grades kindergarten through 12.

(3) The department shall submit a report to the members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies based on the information provided under subsection (1)(a). The report is due 90 days after the end of the calendar year.

Teen center; minimum funding; distribution.

Sec. 1103. Of the funds appropriated in part 1 for adolescent health care services, each teen center, including alternative models, shall receive as minimum funding no less than 115% of what was allocated in fiscal year 1999-2000. The remainder of the appropriated funds under this section, which shall not apply to alternative models, shall be distributed as follows:

(a) Twenty-five percent shall be distributed based on the number of users.

(b) Fifty percent shall be distributed based on the number of visits.

(c) Twenty-five percent shall be distributed based on the number of services provided.

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

Sec. 1104. Before April 1, 2001, the department shall submit a report to the house and senate fiscal agencies 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) Number of women, children, and/or adolescents expected to be served.

(c) Actual numbers served and amounts expended in the categories described in subdivisions (a) and (b) for the fiscal year 1999-2000.

Contracts with local agencies; factors.

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

Federal family planning funds; compliance.

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; program guidelines; priority in funds allocation; options for receipt of funds.

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.

Abortion counseling; use of funds prohibited.

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

Volunteer dental program; report.

Sec. 1109. (1) From the amounts appropriated in part 1 for dental programs, funds shall be allocated to the Michigan dental association for the administration of a volunteer dental program that 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 November 1, 2000, the department shall report to the senate and house of representatives appropriations subcommittees on community health and the senate and house of representatives standing committees on health policy the number of individual patients treated, number of procedures performed, and approximate total market value of those procedures through September 30, 2000.

Receipt of family planning funds; option.

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 86% of the funds appropriated in part 1 for family planning local agreements and the pregnancy prevention program for the direct provision of family planning/pregnancy prevention services.

Communities with high infant mortality rates; allocation.

Sec. 1112. From the funds appropriated 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.

Drug use during pregnancy, neonatal addiction, and fetal alcohol syndrome; targeting families for infant support services.

Sec. 1113. From the funds appropriated in part 1 for special projects, the department shall allocate no less than $200,000.00 to provide education and outreach to targeted populations on the dangers of drug use during pregnancy, neonatal addiction, and fetal alcohol syndrome and further develop its infant support services to target families with infants with fetal alcohol syndrome or suffering from drug addiction.

Nathan Weidner children's advocacy center.

Sec. 1114. From the funds appropriated in part 1 for special projects, the department shall allocate $250,000.00 to the Nathan Weidner children's advocacy center. These funds shall be considered a work project and any unexpended authorization shall be carried forward to fiscal year 2001-2002.

Outreach and support services.

Sec. 1120. The department shall allocate $8,488,600.00 to local public health departments for the purpose of providing EPSDT, maternal and infant support services outreach, and other Medicaid outreach and support services.

Children's respite services.

Sec. 1121. From the funds appropriated in part 1 for special projects, $300,000.00 shall be allocated for children's respite services.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

Children with special health care needs; medical care and treatment; payment.

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 to provide certain medical care and treatment.

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

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

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

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

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

Referral of eligible children.

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

Office for safe schools.

Sec. 1250. From the amount appropriated in part 1 to the office of drug control policy, $200,000.00 shall be transferred to the department of education to fund the office for safe schools.

CRIME VICTIM SERVICES COMMISSION

Crime victim services commission; per diem amount.

Sec. 1301. The per diem amount authorized for the crime victim services commission is $100.00.

OFFICE OF SERVICES TO THE AGING

Community and nutrition services and home services; restriction.

Sec. 1401. The appropriation in part 1 to the office of services to the aging, for community and nutrition services and home services, shall be restricted to eligible individuals at least 60 years of age who fail to qualify for home care services under title XVIII, XIX, or XX of the social security act, chapter 531, 49 Stat. 620.

Additional funds; purchase of generic medicine.

Sec. 1402. (1) The office of services to the aging may receive and expend funds in addition to those authorized in part 1 for the additional purposes described in this section.

(2) Money appropriated in part 1 for the Michigan pharmaceutical program shall be used to purchase generic medicine when available and medically practicable.

Home delivered meals waiting lists; criteria.

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, and respite care; fees.

Sec. 1404. The office of services to the aging may receive and expend fees for the provision of day care, care management, and respite care. The office of services to the aging shall base the fees on a sliding scale taking into consideration the client income. The office of services to the aging shall use the fees to expand services.

Care management systems; expenditure of Medicaid funds.

Sec. 1405. The office of services to the aging may receive and expend Medicaid funds for care management services.

Respite care; use of tobacco settlement funds.

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 plan shall be implemented upon meeting the requirements of section 1657 of this act. The use of the funds shall be for direct respite care. Not more than 10% of the amount allocated under this section shall be expended for administration and administrative purposes.

Long-term care advisor; use of tobacco settlement funds.

Sec. 1407. The appropriation of $3,021,400.00 of tobacco settlement funds to the office of services to the aging for the long-term care advisor 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 plan shall be implemented upon meeting the requirements of section 1657 of this act.

Award of funds on local level.

Sec. 1408. The office of services to the aging shall provide that funds appropriated under this act shall be awarded on a local level in accordance with locally determined needs.

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.

Contract award and funds distribution; criteria.

Sec. 1414. The office of services to the aging shall award contracts and distribute funds only to those projects that are cost effective, meet minimum operational standards, and serve the greatest number of eligible people.

Reporting formats; uniformity.

Sec. 1415. The office of services to the aging shall establish uniform reporting formats for reports submitted by area agencies on aging. Area agencies on aging shall submit reports to the department using the established reporting formats.

Frail elderly not served by Medicaid; 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 services waiver program.

MEDICAL SERVICES ADMINISTRATION

Loan repayment for dentists.

Sec. 1501. 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 care services.

Sec. 1502. The department is directed to continue support of multicultural agencies that provide primary care services from the funds appropriated in part 1.

Palliative care, hospice, and end of life care; room and board payment in hospice residences for low income individuals; allocations.

Sec. 1503. From the amounts appropriated in part 1 for palliative and hospice care, $325,000.00 shall be allocated for education programs on and promotion of palliative care, hospice, and end of life care, and $200,000.00 shall be allocated for a pilot project to assess long-term feasibility of paying the cost of room and board in hospice residences for low income individuals.

Arab American and Chaldean council, and ACCESS.

Sec. 1504. From the funds appropriated in part 1 for primary care services, the department shall appropriate the same level of financing for the Arab American and Chaldean council, and ACCESS that was appropriated in fiscal year 1999-2000.

"Ticket to work and work incentives improvement Act of 1999."

Sec. 1505. The department shall work with the department of career development to explore options available under the federal "Ticket to Work and Work Incentives Improvement Act of 1999".

Federally qualified health centers; enhancement of service capacity.

Sec. 1506. From the funds appropriated in part 1 for primary care services, an amount not to exceed $3,200,000.00 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.

MEDICAL SERVICES

Reimbursement under medical services program; cost report grievances; settlements.

Sec. 1601. 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 third-party sources of payment.

Sec. 1602. (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.

Pharmacy dispensing fee; implementation of pharmacy claims adjudication system.

Sec. 1603. (1) Effective October 1, 2000, the pharmaceutical dispensing fee shall be $3.77 or the usual or customary cash charge, whichever is less. If a Medicaid recipient is 21 years of age or older, the department shall require a $1.00 per prescription copayment, except as prohibited by federal or state law or regulation.

(2) Subsequent to the implementation of an automated pharmacy claims adjudication system, the department shall conduct a study to determine what savings may be accruing to Medicaid pharmacy providers as a result of the establishment of this system. Based on the findings from that study, the department may make a recommendation to the legislature for an adjustment to the pharmacy dispensing fee.

Licensed adult foster care homes and homes for the aged; use of cost of remedial services to determine financial eligibility.

Sec. 1605. 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.

Medicaid adult dental, podiatric, and chiropractic services.

Sec. 1606. Medicaid adult dental services, podiatric services, and chiropractic services shall continue at not less than the level in effect on October 1, 1996, 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.

Copayments on certain services; requirements.

Sec. 1607. 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.

Basic health care needs of indigent persons; program.

Sec. 1609. (1) From the funds appropriated in part 1 for the indigent medical care program, the department shall establish a program that provides for the basic health care needs of indigent persons as delineated in the following subsections.

(2) Eligibility for this program is limited to the following:

(a) Persons currently receiving cash grants under either the family independence program or state disability assistance programs who are not eligible for any other public or private health care coverage.

(b) Any other resident of this state who currently meets the income and asset requirements for the state disability assistance program and is not eligible for any other public or private health care coverage.

(3) All potentially eligible persons, except those defined in subsection (2)(a), who shall be automatically enrolled, may apply for enrollment in this program at local family independence agency offices or other designated sites.

(4) The program shall provide for the following minimum level of services for enrolled individuals:

(a) Physician services provided in private, clinic, or outpatient office settings.

(b) Diagnostic laboratory and x-ray services.

(c) Pharmaceutical services.

(5) Notwithstanding subsection (2)(b), the state may continue to provide nursing facility coverage, including medically necessary ancillary services, to individuals categorized as permanently residing under color of law and who meet either of the following requirements:

(a) The individuals were medically eligible and residing in such a facility as of August 22, 1996 and qualify for emergency medical services.

(b) The individuals were Medicaid eligible as of August 22, 1996, and admitted to a nursing facility before a new eligibility determination was conducted by the family independence agency.

Managed care options; preferences; exception to mandatory enrollment.

Sec. 1611. (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 health plans 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 qualified health plans 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 qualified health plans. 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.

Preauthorization of single-source pharmaceutical products; implementation of prospective drug utilization review and disease management systems; automated pharmacy claims adjudication.

Sec. 1612. (1) The department shall not preauthorize single-source pharmaceutical products except in the following circumstances:

(a) Those single-source pharmaceutical products that have been subject to prior authorization by the department prior to January 1, 1992.

(b) Those single-source pharmaceuticals within the categories specified in section 1927(d)(2) of title XIX, 42 U.S.C. 1396r-8, or for the reasons delineated in section 1927(d)(3) of title XIX, 42 U.S.C. 1396r-8.

(c) Those pharmaceutical products related to the treatment of sexual dysfunction.

(d) Those pharmaceutical products that do not have a medically accepted indication. As used in this subdivision, "medically accepted indication" means any use of a covered outpatient drug that is approved under the federal food, drug, and cosmetic act, that appears in peer reviewed medical literature, or that is accepted by 1 or more of the following compendia: the American hospital formulary service-drug information, the American medical association drug evaluations, the United States pharmacopeia-drug information, or the drugdex information system.

(2) 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 partner for patient advocacy, and Michigan nurses' association.

(3) The department shall continue the process of developing and implementing the automated pharmacy claims adjudication and prospective drug utilization review system and disease management system. The department shall provide bimonthly reports to the members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the progress of the development and implementation of this system.

Mail-order pharmacy program; conditions for implementation.

Sec. 1613. The department may implement a mail-order pharmacy program for the noncapitated portion of the Medicaid program after a study by the department is submitted to the house of representatives and senate appropriations subcommittees on community health and after the repeal of section 17763(a) of the public health code, 1978 PA 368, MCL 333.17763.

Early and periodic screening, diagnosis, and treatment services; access by Medicaid children.

Sec. 1614. (1) The department shall assure that all Medicaid children have timely access to early and periodic screening, diagnosis, and treatment (EPSDT) services as required by federal law. Medicaid managed care plans will provide EPSDT services in accordance with EPSDT policy. Requirements for objective hearing and vision screening may be met by referral to local health departments.

(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 will 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 will be reimbursed for the cost of providing these tests for Medicaid eligible children by the Medicaid program.

Services provided in Michigan schools from federal Medicaid program.

Sec. 1615. (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 appropriation; increase.

Sec. 1616. 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.

Patient-based utilization data from qualified health plans; reports.

Sec. 1617. The department of community health shall obtain patient-based utilization data from those qualified health plans with which the department contracts. The data shall

include immunizations, early and periodic screenings, diagnoses, and treatments, blood lead level testing, and maternal and infant support services. The department shall submit annual reports on patient-based utilization data to the members of the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, the state budget director, and the director of each local health department.

Wage and benefit increases.

Sec. 1618. (1) It is the intent of the legislature that payment increases for enhanced wages and new or enhanced employee benefits shall be provided to those facilities that make application for it to fund the Medicaid program share of wage and employee benefit increases up to the equivalent of 50 cents per employee hour. Employee benefits shall include, but are not limited to, health benefits, retirement benefits, and quality of life benefits such as day care services. Nursing facilities shall be required to document that these wage and benefit increases were actually provided.

(2) The cost of the wage and benefit increases shall be paid from the 5.4% increase appropriated in part 1 for long-term care services.

(3) Funding for the wage and benefit increases authorized in this section shall only be provided to those facilities which offer base pay to competency evaluated nurse aides of not less than $8.50 per employee hour for postprobationary employment not exceeding 120 days after initial hiring. The wage pass-through shall not be used for previously agreed-to wage or benefit increases as a result of collective bargaining or standard step increases.

Medical services to elderly and disabled persons.

Sec. 1619. 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, chapter 531, 49 Stat. 620, 42 U.S.C. 1396a.

Home and community-based services.

Sec. 1620. The department may fund home and community-based services in lieu of nursing home services, for individuals seeking long-term care services, from the nursing home or personal care in-home services line items.

Distribution to children's hospitals.

Sec. 1621. 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.

Enforcement actions; penalty money; carrying forward unexpended money.

Sec. 1622. (1) The department shall implement enforcement actions as specified in the nursing facility enforcement provisions of section 1919 of title XIX, chapter 531, 49 Stat. 620, 42 U.S.C. 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.

Hospice services; amendment of medical services hospice manual.

Sec. 1624. (1) Medical services patients who are enrolled in qualified health plans or capitated clinic plans have the choice to elect hospice services or other services for the terminally ill that are offered by the qualified health plan or clinic plan. 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 C.F.R. part 418.

Funding pool; distribution to hospitals meeting state matching care criteria; establishment of county-based, indigent health care programs; additional counties; replacement of state medical program by locally administered indigent health care program.

Sec. 1626. (1) From the funds appropriated in part 1, the department, subject to the requirements and limitations in this section, shall establish a funding pool of up to $44,012,800.00 for the purpose of enhancing the aggregate payment for medical services hospital services.

(2) For a county with a population of more than 2,000,000 people, the department shall distribute $44,012,800.00 to hospitals if $15,026,700.00 is received by the state from such a county, which meets the criteria of an allowable state matching share as determined by applicable federal laws and regulations. If the state receives a lesser sum of an allowable state matching share from such a county, the amount distributed shall be reduced accordingly.

(3) The department may establish county-based, indigent health care programs that are at least equal in eligibility and coverage to the fiscal year 1996 state medical program.

(4) The department is authorized to establish programs in additional counties which include rural, underserved areas if the expenditures for the programs do not increase state general fund/general purpose costs and local funds are provided.

(5) If a locally administered indigent health care program replaces the state medical program authorized by section 1609 for a given county on or before October 1, 1998, the state general fund/general purpose dollars allocated for that county under this section shall not be less than the general fund/general purpose expenditures for the state medical program in that county in the previous fiscal year.

Cost report.

Sec. 1627. 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.

Program to purchase medical coverage; buy-in; premiums classified as private funds.

Sec. 1634. (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.

Managed care; conditions for implementation and contracting.

Sec. 1635. Implementation and contracting for managed care by Medicaid plans to the department are 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 health plans 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 is prohibited until there are at least 2 qualified health plans with the capacity to adequately serve each geographic area affected. Exceptions may be considered in areas where at least 85% of all area providers are in 1 plan.

(e) Enrollment of recipients of children's special health care services in qualified health plans shall be voluntary during fiscal year 2000-2001.

(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.

Medicaid qualified health plans; requirements.

Sec. 1637. (1) Medicaid qualified health plans shall establish an ongoing internal quality assurance program for health care services provided to Medicaid recipients which includes all of the following:

(a) An emphasis on health outcomes.

(b) Establishment of written protocols for utilization review based on current standards of medical practice.

(c) Review by physicians and other health care professionals of the process followed in the provision of the health care services.

(d) Evaluation of the continuity and coordination of care that enrollees receive.

(e) Mechanisms to detect overutilization and underutilization of services.

(f) Actions to improve quality and assess the effectiveness of the action through systematic follow-up.

(g) Provision of information on quality and outcome measures to facilitate enrollee comparison and choice of health coverage options.

(h) Ongoing evaluation of the plans' effectiveness.

(i) Consumer involvement in the development of the quality assurance program and consideration of enrollee complaints and satisfaction survey results.

(2) Medicaid qualified health plans shall apply for accreditation by an appropriate external independent accrediting organization requiring standards recognized by the department once those plans have met the application requirements. The state shall accept accreditation of a plan by an approved accrediting organization as proof that the plan meets some or all of the state's requirements, if the state determines that the accrediting organization's standards meet or exceed the state's requirements.

(3) Medicaid qualified health plans shall report encounter data, including data on inpatient and outpatient hospital care, physician visits, pharmaceutical services, and other services specified by the department.

(4) Medicaid qualified health plans shall assure that all covered services are available and accessible to enrollees with reasonable promptness and in a manner that assures continuity. Medically necessary services shall be available and accessible 24 hours a day and 7 days a week. Health plans shall continue to develop procedures for determining medical necessity which may include a prior authorization process.

(5) Medicaid qualified health plans shall provide for reimbursement of plan covered services delivered other than through the plan's providers if medically necessary and approved by the plan, immediately required, and that could not be reasonably obtained through the plan's providers on a timely basis. Such services shall be considered approved if the plan 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.

(6) Medicaid qualified health plans shall provide access to appropriate providers, including qualified specialists for all medically necessary services.

(7) Medicaid qualified health plans shall provide the department with a demonstration of the plan's capacity to adequately serve the plan's expected enrollment of Medicaid enrollees.

(8) Medicaid qualified health plans shall provide assurances to the department that it will not deny enrollment to, expel, or refuse to reenroll any individual because of the individual's health status or need for services, and that it will notify all eligible persons of those assurances at the time of enrollment.

(9) Medicaid qualified health plans shall provide procedures for hearing and resolving grievances between the plan and members enrolled in the plan on a timely basis.

(10) Medicaid qualified health plans shall meet other standards and requirements contained in state laws, administrative rules, and policies promulgated by the department.

(11) Medicaid qualified health plans shall develop written plans for providing nonemergency medical transportation services funded through supplemental payments made to the plans by the department, and shall include information about transportation in their member handbook.

Lock-in period.

Sec. 1640. (1) The department may require a 12-month lock-in to the qualified health plan 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 health plans for any reason within the initial 90 days of enrollment.

Expedited complaint review procedure; toll-free telephone number; reports.

Sec. 1641. (1) The department shall provide an expedited complaint review procedure for Medicaid eligible persons enrolled in qualified health plans 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) Semiannual 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, and the department's health plans advisory council.

Beneficiary services provided by enrollment contractor.

Sec. 1642. The department shall require the enrollment contractor to provide beneficiary services. These services shall include all of the following:

(a) Contacting eligible Medicaid beneficiaries.

(b) Providing education on managed care.

(c) Providing information through a toll-free number regarding available health plans and their primary care providers available in the Medicaid beneficiaries area.

(d) Entering the beneficiaries health plan choice in the information system for communication to the state and the health plan, written notification to the beneficiary regarding their health plan choice, and notice of their right to change plans consistent with federal guidelines.

(e) Guiding beneficiaries through both health plan and state complaint and fair hearing processes, including helping the beneficiary fill out required forms.

(f) Being available to attend a hearing with a beneficiary if requested by the beneficiary to provide objective information regarding events that have occurred pertinent to the beneficiary.

Direct payment to hospitals serving indigent patients.

Sec. 1643. 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.

Prenatal care.

Sec. 1644. The mother of an unborn child shall be eligible for medical services benefits for herself and her child if all other eligibility factors are met. To be eligible for these benefits, the applicant shall provide medical evidence of her pregnancy. If she is unable to provide the documentation, payment for the examination may be at state expense. The department of community health shall undertake measures necessary to ensure that necessary prenatal care is provided to medical services eligible recipients.

Protected income level for Medicaid coverage.

Sec. 1645. (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 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 conservative charges.

Sec. 1646. 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.

Terminally ill and chronically ill individuals; programs preserving dignity and rights.

Sec. 1656. 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.

Long-term care plan.

Sec. 1657. The long-term care working group established in section 1657 of 1998 PA 336 shall continue to exist until the long-term care working group has completed its work on a written long-term care plan. The department shall not implement a long-term care plan until the expiration of 24 days during which at least 1 house of the legislature convenes after the long-term care working group has submitted the written long-term care plan to the senate majority leader, the speaker of the house, the senate and house appropriations subcommittees on community health, and the state budget director.

Psychiatric residency training program.

Sec. 1658. Of the funds appropriated in part 1 for graduate medical education in the hospital services and therapy line item appropriation, $3,635,100.00 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.

Graduate medical education.

Sec. 1659. From the amounts appropriated in part 1 for hospital services, the department shall allocate for graduate medical education no less than was allocated for graduate medical education in fiscal year 1999-2000.

Sections applying to Medicaid managed care programs.

Sec. 1660. 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, MI Choice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 217, 402, 404, 413, 414, 1611, 1614, 1617, 1624, 1635, 1637, 1640, 1641, 1642, 1643, 1662, 1663, 1690, 1691, 1692, 1705, and 1706.

Maternal and infant support services offered by qualified health plan.

Sec. 1662. (1) The department shall include provision in the contracts with health plans for full responsibility for well child visits and maternal and infant support services as described in Medicaid policy. This responsibility will also be included in the information distributed by the health plans to the members.

(2) The department shall develop and implement a budget neutral enrollment based incentive program to encourage qualified health plans to improve infant and children's health outcomes by improving access to maternal and infant support services (MSS/ISS) and to well child examinations. Qualified health plans with the most improved performance will be eligible for automatic beneficiary enrollment and those plans who fail to improve will be ineligible for new enrollment. Qualified health plans will refund to the department any unexpended MSS/ISS capitation below the fee for service equivalent MSS/ISS capitation in fiscal year 1996-97.

(3) Maternal and infant support services shall continue to be provided through state certified providers.

Work group on EPSDT and maternal and infant support services.

Sec. 1663. The department shall continue a work group on EPSDT and maternal and infant support services. The work group shall be made up of consumers, advocates, health care providers, and health plan representatives. The work group shall, at a minimum, establish an outreach program to educate providers on the requirements of EPSDT screening, and advise the department on providing targeted assistance to health plans that are screening less than 60% of the child members that are eligible for EPSDT services and recommend strategies to improve access to maternal and infant support services.

MIChild program; eligibility; contracts; payments.

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 health maintenance organization, 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. 1673. 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; duration of eligibility.

Sec. 1674. The department may provide up to 1 year of continuous eligibility to a family made eligible for the MIChild program unless the family's status changes and its members no longer meet the eligibility criteria as specified in the federally approved MIChild state plan.

MIChild program; premiums.

Sec. 1676. 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 $5.00 for a family.

MIChild program; copayments not required.

Sec. 1677. The department shall not require copayments under the MIChild program.

Eligibility changes between Medicaid and MIChild programs.

Sec. 1678. Families 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; income eligibility.

Sec. 1681. 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; medically necessary services; availability.

Sec. 1682. The MIChild program shall provide all benefits available under the state employee insurance plan that are delivered through the qualified health plans 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.

Patient rights and responsibilities; pamphlet.

Sec. 1686. The department shall make available to health care providers a pamphlet identifying patient rights and responsibilities described in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

Nursing home rates.

Sec. 1687. 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.

Hospital emergency room; requirements.

Sec. 1690. (1) Reimbursement for medical services to screen and stabilize a Medicaid recipient in a hospital emergency room shall not be made contingent on obtaining prior authorization from the recipient's qualified health plan. If the recipient is discharged from the emergency room, the hospital shall notify the recipient's qualified health plan 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 qualified health plan prior to admitting the recipient.

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

(4) Effective October 1, 2000, the department shall implement a 2-tier case rate, not to exceed the corresponding Medicare rates, for all emergency physician professional charges as recommended by the emergency services workgroup authorized in section 1690 of 1999 PA 114. The case rate shall be determined based upon the final disposition of the patient. Those patients who are treated and sent back to their residence shall form 1 group (treat and release). The second group shall be comprised of those patients who are treated and either transferred to another health facility or kept in the hospital as admitted or observed patients (treat and admit/transfer).

Uniform Medicaid billing form.

Sec. 1691. (1) It is the intent of the legislature that a uniform Medicaid billing form be developed by the department in consultation with affected Medicaid providers. Every 2 months, the department shall provide reports to members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the progress of this initiative.

(2) Until such time as a uniform billing form is developed and implemented, or unless otherwise provided in state law, the following shall apply to Medicaid qualified health plans:

(a) If a billing form is received by a qualified health plan with a noncorrectable error, the qualified health plan shall return the form within 10 business days to the billing provider with plain language instructions as to what items need to be corrected.

(b) If a qualified health plan fails to provide reimbursement for at least 90% of its clean claims within 30 days of receipt, the qualified health plans shall be subject to an interest charge based on the value of the unpaid claims. Interest shall be paid at the rate specified in section 3902(a) of title 31 of the United States Code, 31 U.S.C. 3902. As used in this subdivision, "clean claim" means a claim that has no defect or impropriety, including lack of required substantiating documentation for noncontracting providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

(c) If a qualified health plan has followed the procedure specified in subdivision (a), the required time for reimbursement does not begin until a corrected billing form has been received.

(d) A Medicaid provider that submits a duplicate of a claim that has been denied or returned with notice that it is incomplete or incorrect shall be subject to a service charge for each duplicate claim, in an amount determined by the department, if the duplicate claim is submitted without completion, correction, or further information that addresses the denial or return.

(3) The department shall hold regular Medicaid billing seminars targeted to both qualified health plans and Medicaid providers. The number and locations of these seminars should be sufficient to provide reasonable access to qualified health plans and Medicaid providers throughout the state. The department shall provide quarterly reports to the members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the number of seminars, their content and location, and the number of persons attending these seminars.

EPSDT and MSS/ISS provisions; statistic sampling for certain information; compilation and report.

Sec. 1692. (1) The department shall do or demonstrate that it has accomplished all of the following concerning the provision of early and periodic screening, diagnosis, and treatment (EPSDT) and maternal and infant support services (MSS/ISS):

(a) Explore the feasibility of developing a uniform encounter form for EPSDT services, MSS/ISS referral, and MSS/ISS screening and services.

(b) Require each qualified health plan to evaluate 100% of pregnant Medicaid enrollees for possible MSS/ISS screening referral during the initial pregnancy services visit, using uniform screening and referral criteria.

(c) Require each qualified health plan to notify the department and the appropriate local health department of all MSS/ISS screening referrals, and require all MSS/ISS screening and service providers to notify the department and the appropriate local health department of Medicaid clients who fail to keep MSS/ISS appointments.

(d) Prohibit qualified health plans from requiring prior authorization for their contracted providers for any EPSDT screening and diagnostic service, for MSS/ISS screening referral, or for up to 3 MSS/ISS service visits.

(e) Coordinate the provision of MSS/ISS services with the women, infants, and children supplemental nutrition (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.

(2) The department shall require the external quality review contractor to conduct a statistically significant sampling of the health records of Medicaid eligible clients of all qualified health plans for all of the following information:

(a) The number of Medicaid enrollees under age 19.

(b) The number of Medicaid enrollees receiving at least 1 EPSDT service.

(c) The number and type of EPSDT services rendered.

(d) The immunization status of each EPSDT eligible enrollee who is seen by a plan provider.

(e) The number of enrollees receiving blood lead screening.

(f) The number of referrals to local health departments for blood lead screening, immunization, or objective hearing and vision screening services.

(g) The number of pregnant Medicaid enrollees.

(h) The number of referrals for MSS/ISS assessment.

(i) The number of MSS/ISS assessments performed.

(j) The number and description of MSS/ISS visits or services delivered.

(k) The number of prenatal visits per pregnant enrollee.

(*l*) Fetal or infant death, birth weight, and infant morbidity data for Medicaid enrollees.

(3) The department shall compile and report the information required in subsection (2) and a report on the distribution of MSS/ISS providers across the state to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director no later than February 1, 2001.

Michigan association of health plans and Michigan association for local public health; service delivery and coordination; report.

Sec. 1693. 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 and report on those activities in conjunction with the report required in section 1692(3).

Dental services claims processing.

Sec. 1694. (1) By October 1, 2000, the department shall implement procedures for claims processing that use or accept a standard scannable form for dental claims.

(2) By October 1, 2000, the department shall implement procedures for claims processing that allow participating dental providers to submit claims for reimbursement for covered dental services using the American dental association's "code on dental procedures and nomenclature" as contained in the latest edition of the American dental association's publication "current dental terminology".

(3) By October 1, 2001, the department shall implement procedures for claims processing that allow participating dental providers to submit claims electronically.

Elder prescription insurance coverage program (EPIC).

Sec. 1695. (1) Effective January 1, 2001, it is the intent of the legislature that an elder prescription insurance coverage program will be established, referred to in this section as the EPIC program. The guiding principles of this program are all of the following:

(a) To enhance access to prescription medications for low income elderly residents of this state.

(b) To make that access meaningful by reducing the cost to senior citizens to obtain prescription medications.

(c) To assist the elderly in understanding how prescription medications can be beneficial in treating diseases, illnesses, and conditions that are more prevalent in the aged.

(d) To provide the means by which those persons who prescribe and dispense prescription medications for the elderly are better able to recognize those prescription situations in which combinations of new and/or existing drugs, or other factors, could result in an adverse drug interaction in an elderly person.

(e) The program developed pursuant to this section is not an entitlement and benefits are limited to the level supported by the funding explicitly appropriated in this or subsequent acts.

(f) Emergency prescription assistance shall continue to be available through the program.

(2) In furthering these guiding principles, the operational parameters of the EPIC program shall include at least all of the following:

(a) Limiting eligibility to Michigan residents who are over the age of 64, who have household incomes at or below 200% of poverty, and who are not eligible for Medicaid.

(b) Establishing variable premium rates based on a percentage of household income, which rate shall be not more than 5% of household income if household income is 200% of poverty and shall be zero if household income is 100% or less of poverty.

(c) A mechanism, such as limiting the number of policies sold, to ensure that expenditures do not exceed available revenue.

(3) The EPIC program shall not be implemented until after an automated pharmacy claims adjudication and prospective drug utilization review system is operational.

(4) The EPIC program shall not be implemented until section 273 of the income tax act of 1967, 1967 PA 281, MCL 206.273, is repealed.

(5) The Michigan emergency pharmaceutical program for seniors shall be continued until the EPIC program is fully implemented.

Dental fees; funds increase.

Sec. 1696. From the funds appropriated in part 1 for auxiliary medical services, dental fees, including fees for adult dental services, shall be increased 5% and the healthy kids dental project shall be expanded.

Rural health initiative.

Sec. 1697. (1) The department shall continue the rural health initiative started in fiscal year 1999-2000 with emphasis on rural emergency medical services system, medical equipment, and technology. From the funds appropriated in part 1 for the rural health initiative, $4,000,000.00 shall be allocated as matching grants for the purpose of defraying the costs associated with training and retaining rural emergency medical service technicians, $1,000,000.00 for the purchase of defibrillators, and the remainder for other medical equipment and technology.

(2) The department shall maximize the use of federal matching funds for these projects whenever possible.

Medicaid coverage relating to pregnancy.

Sec. 1698. (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.

(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. In addition, the applicant shall receive a listing of Medicaid physicians and managed care plans in the immediate vicinity of the applicant's residence.

(3) An applicant that selects a Medicaid provider, other than a managed care plan, from which to receive pregnancy services, shall not be required to enroll in a managed care plan until the end of the second month postpartum.

(4) 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.

Compiler's note: Sec. 1695 of 2000 PA 296 was repealed by 2000 PA 506, Imd. Eff. Jan. 16, 2001.

(5) 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.

Personal care services rate.

Sec. 1700. The personal care services rate shall be increased by 4%.

Outpatient adjustor payment.

Sec. 1701. The department shall distribute the 7% economic increase for outpatient services in the hospital services and therapy line as an adjustor payment to hospitals based on the percentage of total outpatient hospital billings for Medicaid fee-for-service and managed care services by each hospital. The department shall target the funds to hospitals under contract with qualified health plans subject to the provisions of section 1706. In addition, effective October 1, 2000, the department shall convert the fiscal year 1999-2000 outpatient adjustor payment to a hospital outpatient service fee increase as part of an update of the resource-based relative value fee methodology pursuant to section 1703.

Physician services; rate increase.

Sec. 1702. (1) Effective October 1, 2000, the department shall convert $2,760,000.00 of the fiscal year 1999-2000 4% increase for physician services that was distributed as a physician disproportionate payment during fiscal year 1999-2000 and the $12,420,000.00 appropriated in part 1 for a 9% economic increase for physician services to an 11% surcharge that shall be applied to all physician payments.

(2) No later than April 1, 2001, the department shall utilize the funds specified in subsection (1) and the remaining funds appropriated in part 1 for an increase in physician services rates to update the resource based relative value fee methodology as delineated in section 1703. It is the intent of the legislature that the remaining portion of the fiscal year 1999-2000 physician services increase be used as a fee adjustor for primary care services targeted to physicians under contract with a qualified health plan.

(3) These increases shall also apply to the maternal and infant support services procedure code revision specified in the medical services administration bulletin 00-02 issued July 1, 2000, with an effective date of September 1, 2000.

Reimbursement of physician and hospital outpatient fee; workgroup; report.

Sec. 1703. (1) It is the intent of the legislature that on, or before, April 1, 2001 the Medicaid payment fee schedule used to reimburse physicians and hospitals for outpatient services shall be rebased. This process shall use the latest available Medicare relative value weights used in the Medicare physician reimbursement methodology and the funds available for this rebasing shall include those funds that were being paid as an 11% surcharge to each physician services. The funds available for the rebasing of hospital outpatient fee screens shall include the fee screen increase that was granted hospitals for outpatient services on October 1, 2000.

(2) To further this end, the department shall establish a workgroup consisting of, at a minimum, department staff, and 1 representative each from Michigan state medical society, Michigan association of osteopathic physicians, and Michigan health and hospital association, and 1 designee each of the respective chairs of the senate and house of representatives appropriations subcommittees on community health.

(3) The purpose of this workgroup is to ensure that the model used establishes that payment rates are reflective of the proper weights being assigned to each procedure code,

that procedure codes without Medicare equivalents are assigned reasonable proxies, and that any anomalous results are analyzed and adjusted to reflect the intent of this section. In addition, this workgroup shall ensure that no element of the rebased fee schedule exceeds the Medicare payment rate for that procedure, except as may be allowed by federal law or regulation.

(4) This workgroup shall provide a bimonthly report to the chairs of the senate and house of representatives appropriations subcommittees on community health and senate and house fiscal agencies, as to the activities of the workgroup and the expected date for the completion of this rebasing.

Long-term care innovations grant; report on results.

Sec. 1704. By September 30, 2001, the department shall report on the results of the long-term care innovations grants allocated as 1-time funding in fiscal year 1999-2000.

Automated Medicaid eligibility verification services; contracts.

Sec. 1705. The department may contract with multiple vendors to provide automated Medicaid eligibility verification services to providers. For providers with contracts with qualified health plans who elect to utilize the services of 1 of these vendors, the department shall pay all of the transaction fee associated with this eligibility verification service. The department shall maintain a toll-free voice eligibility verification service at no cost to providers. The provisions in this section shall apply to providers treating Medicaid patients under the fee for service system as long as they have a contract with a qualified health plan to provide services to qualified health plan enrollees.

Contracts with hospitals within reasonable distance of enrollees; waiver.

Sec. 1706. Qualified health plans are required to have contracts with hospitals within a reasonable distance from their enrollees. The department may waive this requirement if it certifies that after good faith negotiations, no reasonable agreement could be reached among the parties. In the absence of a contract with qualified health plans, the qualified health plan must reimburse the hospital for medically necessary, appropriately authorized services arranged by a physician with admitting privileges at the hospital at Medicaid fee-for-service rates.

Medicaid reimbursement of physician services; payment methodology update.

Sec. 1707. It is the intent of the legislature that the department shall update the payment methodology for Medicaid reimbursement of physician services and move toward the resource-based relative value system used by the health care financing administration.

Medicaid psychotropic drug utilization advisory committee.

Sec. 1708. The department, in conjunction with community mental health services programs, shall establish a Medicaid psychotropic drug utilization advisory committee which shall consist of 1 representative from the mental health and substance abuse services administration, 1 representative from the medical services administration, 1 representative from the Michigan association of community mental health boards, 1 representative from the Michigan pharmacists association, 1 representative from the Michigan state medical society, 1 representative from the Michigan association of osteopathic physicians, 1 representative from the Michigan psychiatric society, 2 representatives from

Compiler's note: Sec. 1706 of 2000 PA 296 was repealed by Sec. 1302 of 2001 PA 81, Eff. July 25, 2001.

the pharmaceutical industry that have either research or manufacturing facilities located within the state, and 2 representatives appointed by the Michigan partners for patient advocacy to represent the concerns of consumer, family, advocacy, and children's groups. The committee shall maintain a liaison with the Medicaid drug utilization review board and shall report to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies not later than September 30, 2001.

School based health clinics.

Sec. 1709. A school district eligible for school based health service funds may use a portion of those funds for school based health clinics that serve children in kindergarten through seventh grade.

Distribution of disproportionate share hospital payments; report.

Sec. 1710. It is the sense of the legislature that disproportionate share hospital payments and other similar adjustor payments should be equitably distributed on a statewide basis. As such, no later than May 1, 2001, the department shall provide a report to the chairs of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the methodology used to distribute disproportionate share hospital payments and other similar adjustor payments. This report shall include the existing distribution of these funds by geographic location.

Repeal of sections 2201 to 2203 of 1999 PA 114.

Enacting section 1. Part 1b, section 130 of 1999 PA 114, and part 2b, sections 2201 to 2203 of 1999 PA 114, are repealed.

This act is ordered to take immediate effect.
Approved July 19, 2000.
Filed with Secretary of State July 21, 2000.