[No. 336]

(SB 908)

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 years ending September 30, 1998 and September 30, 1999; to provide for the expenditure of such appropriations; to create funds; to provide for reports; to prescribe the powers and duties of certain local and state agencies and departments; and to provide for disposition of fees and other income received by the various state agencies.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS

Appropriation for fiscal year ending September 30, 1999; 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, 1999, 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 7.0		
Full-time equated classified positions....6,298.3		
Average population 1,478.0		
GROSS APPROPRIATION	$	7,484,077,800
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		69,711,600
ADJUSTED GROSS APPROPRIATION	$	7,414,366,200
Federal revenues:		
Total federal revenues		3,682,772,100
Special revenue funds:		
Total local revenues		846,448,200
Total private revenues		46,284,900
Total other state restricted revenues		297,568,400
State general fund/general purpose	$	2,541,292,600

Departmentwide administration.

Sec. 102. DEPARTMENTWIDE ADMINISTRATION		
Full-time equated unclassified positions 7.0		
Full-time equated classified positions....489.7		
Director and other unclassified—7.0 FTE positions	$	540,200
Community health advisory council		28,900
Departmental administration and management—479.7 FTE positions		45,131,000
Worker's compensation program—1.0 FTE position		13,277,900
Rent		3,803,300
Building occupancy charges		3,153,300
Developmental disabilities council and projects—9.0 FTE positions		2,259,700
GROSS APPROPRIATION	$	68,194,300

	For Fiscal Year Ending Sept. 30, 1999
Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from the department of treasury, Michigan state hospital finance authority	$ 92,600
Intradepartmental transfer - automated data processing charges	3,510,400
Federal revenues:	
Total federal revenues	14,080,200
Special revenue funds:	
Private funds	20,800
Total other state restricted revenues	3,280,500
State general fund/general purpose	$ 47,209,800

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....123.2	
Mental health/substance abuse program administration—114.2 FTE positions	$ 9,639,600
Consumer involvement program	291,600
Gambling addiction	3,000,000
Southwest community partnership	1,997,200
Protection and advocacy services support	1,318,300
Mental health initiatives for older persons	1,165,800
Purchase of psychiatric residency training	3,635,100
Community residential and support services—9.0 FTE positions	8,450,900
Highway safety projects	2,337,200
Program enhancement, evaluation, and data services	1,137,600
Federal and other special projects	7,427,200
GROSS APPROPRIATION	$ 40,400,500
Appropriated from:	
Federal revenues:	
Total federal revenues	14,787,500
Special revenue funds:	
Total private revenues	125,000
Total other state restricted revenues	3,682,300
State general fund/general purpose	$ 21,805,700

Community mental health/substance abuse services programs.

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

Full-time equated classified positions....14.0	
Community mental health programs	$ 1,389,995,100
Respite services	3,000,000
CMHSP, purchase of state services contracts	157,407,400

	For Fiscal Year Ending Sept. 30, 1999
Civil service charges	$ 2,606,400
Omnibus reconciliation act implementation— 9.0 FTE positions	12,388,700
Federal mental health block grant—2.0 FTE positions	10,847,000
Pilot projects in prevention for adults and children— 2.0 FTE positions	1,516,200
Homelessness formula grant program—1.0 FTE position	1,251,800
Chemically-dependent pregnant women and children program	2,100,000
State disability assistance program substance abuse services	6,600,000
Community substance abuse prevention, education and treatment programs	79,540,400
GROSS APPROPRIATION	$ 1,667,253,000
Appropriated from:	
Federal revenues:	
Total federal revenues	619,793,000
Special revenue funds:	
Total other state restricted revenues	6,242,400
State general fund/general purpose	$ 1,041,217,600

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	1,478.0
Full-time equated classified positions	4,753.0
Caro regional mental health center - psychiatric hospital - adult—512.0 FTE positions	$ 30,038,900
Average population	180.0
Kalamazoo psychiatric hospital - adult— 402.0 FTE positions	26,325,200
Average population	130.0
Northville psychiatric hospital - adult— 860.0 FTE positions	59,815,300
Average population	350.0
Walter P. Reuther psychiatric hospital - adult— 432.0 FTE positions	31,201,000
Average population	210.0
Hawthorn center - psychiatric hospital - children and adolescents—325.0 FTE positions	21,010,900
Average population	118.0
Mount Pleasant center - developmental disabilities— 510.0 FTE positions	30,086,100
Average population	210.0

		For Fiscal Year Ending Sept. 30, 1999
Southgate center - developmental disabilities—		
256.0 FTE positions	$	15,928,600
Average population 70.0		
Center for forensic psychiatry—482.0 FTE positions		32,021,300
Average population 210.0		
Center for forensic psychiatry - outpatient evaluation—		
40.0 FTE positions		3,201,500
Forensic mental health services provided to the		
department of corrections—921.0 FTE positions		65,283,100
Revenue recapture		750,000
IDEA, federal special education		92,000
Special maintenance and equipment		959,000
Purchase of medical services for residents of		
hospitals and centers		2,374,000
Closed site, transition, and related costs—13.0 FTE positions		455,500
Severance pay		1,896,000
Maintenance of property being leased or rented		95,000
Therapeutic work training program		345,600
Gifts and bequests for patient living and treat-		
ment environment		2,000,000
GROSS APPROPRIATION	$	323,879,000
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of corrections		65,283,100
Federal revenues:		
Total federal revenues		28,953,100
Special revenue funds:		
CMHSP, purchase of state services contracts		157,407,400
Other local revenues		15,389,000
Private funds		2,000,000
Total other state restricted revenues		15,987,800
State general fund/general purpose	$	38,858,600

Public health administration.

Sec. 106. PUBLIC HEALTH ADMINISTRATION

Full-time equated classified positions 88.3		
Executive administration—15.5 FTE positions	$	1,271,300
Minority health grants and contracts		650,000
Vital records and health statistics—72.8 FTE positions		5,606,700
GROSS APPROPRIATION	$	7,528,000
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from family independence agency		133,300
Federal revenues:		
Total federal revenues		2,719,300
Special revenue funds:		
Total other state restricted revenues		1,704,600
State general fund/general purpose	$	2,970,800

	For Fiscal Year Ending Sept. 30, 1999
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	$ 19,459,800
Immunization local agreements	16,137,100
Immunization program management and field support—	
7.7 FTE positions	1,849,100
Sexually transmitted disease control local agreements	6,805,700
Sexually transmitted disease control management	
and field support—26.8 FTE positions	2,678,700
GROSS APPROPRIATION	$ 46,930,400
Appropriated from:	
Federal revenues:	
Total federal revenues	30,631,100
Special revenue funds:	
Local funds	242,700
Private funds	710,000
Total other state restricted revenues	11,783,200
State general fund/general purpose	$ 3,563,400
Laboratory services.	
Sec. 108. LABORATORY SERVICES	
Full-time equated classified positions....118.2	
Laboratory services administration—98.7 FTE positions	$ 7,894,900
EPSDT blood lead screening—6.0 FTE positions	667,700
Lyme disease	75,000
Newborn screening services—13.5 FTE positions	1,765,700
GROSS APPROPRIATION	$ 10,403,300
Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from corrections	232,600
Interdepartmental grant from environmental quality	379,000
Federal revenues:	
Total federal revenues	1,139,700
Special revenue funds:	
Total other state restricted revenues	2,467,900
State general fund/general purpose	$ 6,184,100
Epidemiology.	
Sec. 109. EPIDEMIOLOGY	
Full-time equated classified positions....31.5	
AIDS surveillance and prevention program—	
7.0 FTE positions	$ 2,234,800
Disease surveillance—3.4 FTE positions	568,000
Epidemiology administration—21.1 FTE positions	3,628,000
Tuberculosis control and recalcitrant AIDS program	699,500
GROSS APPROPRIATION	$ 7,130,300

		For Fiscal Year Ending Sept. 30, 1999
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of environmental quality	$	80,600
Federal revenues:		
Total federal revenues		4,873,700
Special revenue funds:		
Total other state restricted revenues		281,000
State general fund/general purpose	$	1,895,000

Local health administration and grants.

Sec. 110. LOCAL HEALTH ADMINISTRATION AND GRANTS

Full-time equated classified positions....3.0		
Implementation of 1993 PA 133	$	100,000
Lead abatement program—3.0 FTE positions		4,900,000
Local health services		142,300
Local public health operations		38,712,600
Medical services cost reimbursement to local health departments		1,800,000
Special populations health care		620,600
Training and evaluation		320,000
GROSS APPROPRIATION	$	46,595,500
Appropriated from:		
Federal revenues:		
Total federal funds		6,855,500
Special revenue funds:		
Total other state restricted revenues		243,500
State general fund/general purpose	$	39,496,500

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	$	1,700,000
Alzheimer's information network		250,000
Cancer prevention and control program—13.6 FTE positions		13,393,700
Chronic disease prevention		1,496,800
Diabetes local agreements		3,229,900
Employee wellness program grants (includes $50.00 per diem and expenses for the risk reduction and AIDS policy commission)		4,250,000
Health education, promotion, and research programs—11.9 FTE positions		2,409,400
Injury control intervention project		1,017,300

		For Fiscal Year Ending Sept. 30, 1999
Physical fitness, nutrition, and health	$	1,250,000
Public health traffic safety coordination		152,600
School health and education programs		2,080,000
Smoking prevention program—6.2 FTE positions		7,176,700
Violence prevention—2.0 FTE positions		2,846,600
GROSS APPROPRIATION	$	41,253,000
Appropriated from:		
Federal revenues:		
Total federal funds		12,029,700
Special revenue funds:		
Total other state restricted revenues		26,452,400
State general fund/general purpose	$	2,770,900

Community living, children, and families.

Sec. 112. COMMUNITY LIVING, CHILDREN, AND FAMILIES

Full-time equated classified positions	119.8	
Adolescent health care services	$	2,892,300
Community living, children, and families administration—114.3 FTE positions		13,249,300
Dental programs		260,400
Dental program for persons with developmental disabilities		151,000
Family planning local agreements		7,392,600
Family support subsidy		14,014,400
Lead paint program		491,800
Local MCH services		8,354,200
Maternal and child health outreach and advocacy programs		6,200,000
Migrant health care		166,100
Newborn screening follow-up and treatment services		1,729,400
Pediatric AIDS prevention and control		800,000
Pregnancy prevention program		7,296,100
Prenatal care outreach and service delivery support		7,987,900
Special projects—5.5 FTE positions		4,271,400
Sudden infant death syndrome program		521,300
Women, infants, and children program local agreements and food costs		145,679,200
GROSS APPROPRIATION	$	221,457,400
Appropriated from:		
Federal revenues:		
Total federal revenue		146,657,800
Special revenue funds:		
Private funds		41,954,100
Total other state restricted revenues		9,172,200
State general fund/general purpose	$	23,673,300

		For Fiscal Year Ending Sept. 30, 1999
Children's special health care services.		
Sec. 113. CHILDREN'S SPECIAL HEALTH CARE SERVICES		
Full-time equated classified positions....66.6		
Program administration—66.6 FTE positions	$	4,983,200
Amputee program		184,600
Bequests for care and services		1,104,600
Case management services		3,923,500
Conveyor contract		559,100
Medical care and treatment		117,433,700
GROSS APPROPRIATION	$	128,188,700
Appropriated from:		
Federal revenues:		
Total federal revenue		57,934,300
Special revenue funds:		
Private bequests		750,000
Total other state restricted revenues		3,898,500
State general fund/general purpose	$	65,605,900
Office of drug control policy.		
Sec. 114. OFFICE OF DRUG CONTROL POLICY		
Full-time equated classified positions....15.0		
Drug control policy—15.0 FTE positions	$	1,533,900
Anti-drug abuse grants		33,400,000
GROSS APPROPRIATION	$	34,933,900
Appropriated from:		
Federal revenues:		
Total federal revenue		34,760,200
State general fund/general purpose	$	173,700
Crime victim services commission.		
Sec. 115. CRIME VICTIM SERVICES COMMISSION		
Full-time equated classified positions....9.0		
Grants administration services—9.0 FTE positions	$	775,400
Justice assistance grants		9,000,000
Crime victim rights services grants		6,274,600
GROSS APPROPRIATION	$	16,050,000
Appropriated from:		
Federal revenues:		
Total federal revenue		9,871,300
Special revenue funds:		
Total other state restricted revenues		5,684,700
State general fund/general purpose	$	494,000
Office of services to the aging.		
Sec. 116. OFFICE OF SERVICES TO THE AGING		
Full-time equated classified positions....36.5		
Commission (per diem $50.00)	$	10,500

		For Fiscal Year Ending Sept. 30, 1999
Office of services to aging administration—		
36.5 FTE positions	$	3,641,400
Community services		26,863,400
Nutrition services		28,185,700
Senior volunteer services		4,220,800
Senior citizen centers staffing and equipment		1,140,700
Employment assistance		2,632,700
DAG commodity supplement		6,978,800
Michigan pharmaceutical program		6,000,000
Respite care program		3,500,000
GROSS APPROPRIATION	$	83,174,000
Appropriated from:		
Federal revenues:		
Total federal revenue		39,171,400
Special revenue funds:		
Total private revenue		125,000
Total other state restricted revenue		10,000,700
State general fund/general purpose	$	33,876,900

Medical services administration.

Sec. 117. MEDICAL SERVICES ADMINISTRATION

Full-time equated classified positions	352.5	
Salaries and wages—352.5 FTE positions	$	20,226,200
Contractual services, supplies, and materials		21,661,600
Travel and equipment		193,200
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
Primary care services		2,140,600
GROSS APPROPRIATION	$	48,911,400
Appropriated from:		
Federal revenues:		
Total federal revenues		31,250,000
Special revenue funds:		
Private funds		100,000
Total other state restricted revenues		752,600
State general fund/general purpose	$	16,808,800

Medical services.

Sec. 118. MEDICAL SERVICES

Hospital services and therapy	$	618,412,100
Hospital disproportionate share payments		45,000,000
Physician services		162,532,900
Medicare premium payments		104,372,400
Pharmaceutical services		205,054,400
Home health services		34,407,500
Transportation		4,358,900

		For Fiscal Year Ending Sept. 30, 1999
Auxiliary medical services	$	48,999,700
Long-term care services		942,969,200
Health plan services		1,253,274,700
Medicaid outreach		5,000,000
MIChild outreach		3,327,800
MIChild program		57,567,100
Personal care services		24,262,000
Maternal and child health		9,234,500
Adult home help		138,479,200
Social services to the physically disabled		1,344,900
Subtotal basic medical services program		3,658,597,300
Outpatient hospital adjustor		44,012,800
Indigent medical care program		27,431,300
School based services		142,782,300
Special adjustor payments		818,971,400
Subtotal special medical services payments		1,033,197,800
GROSS APPROPRIATION	$	4,691,795,100
Appropriated from:		
Federal revenues:		
Total federal revenues		2,627,264,300
Special revenue funds:		
Local revenues		673,409,100
Private funds		500,000
Tobacco company litigation fund		50,000
Total other state restricted revenues		195,884,100
State general fund/general purpose	$	1,194,687,600

PART 1A

LINE-ITEM APPROPRIATIONS

Appropriation for fiscal year ending September 30, 1998; department of community health.

Sec. 151. 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, 1998, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH

GROSS APPROPRIATION	$	500,000
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	500,000
Federal revenues:		
Total federal revenues		0

		For Fiscal Year Ending Sept. 30, 1999
Special revenue funds:		
Total local revenues	$	0
Total private revenues		0
Total other state restricted revenues		500,000
State general fund/general purpose	$	0

Infectious disease control.

Sec. 153. INFECTIOUS DISEASE CONTROL

Disease surveillance	$	500,000
GROSS APPROPRIATION	$	500,000
Appropriated from:		
Special revenue funds:		
Total other state restricted revenues		500,000
State general fund/general purpose	$	0

PART 2

PROVISIONS CONCERNING APPROPRIATIONS

GENERAL SECTIONS

Total state spending; spending to local units of government.

Sec. 201. (1) Pursuant to section 30 of article IX of the state constitution of 1963, total state spending in part 1 from state sources for fiscal year 1998-99 is estimated at $2,838,861,000.00. The itemized statement below identifies appropriations from which spending to units of local government will occur:

DEPARTMENTWIDE ADMINISTRATION		
Departmental administration and management	$	1,618,000
COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS		
Homelessness formula grant program - state match		708,800
Pilot projects in prevention for adults and children		1,516,200
Community substance abuse prevention, education, and treatment programs		19,419,700
Community mental health programs		829,927,300
Respite services		3,000,000
OBRA implementation		2,459,100
INFECTIOUS DISEASE CONTROL		
AIDS prevention, testing, and care programs		1,466,800
Sexually transmitted disease control programs		452,900
LOCAL HEALTH ADMINISTRATION AND GRANTS		
Special population health care		29,600
Local public health operations		38,712,600

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION		
Cancer prevention and control program	$	397,000
Diabetes local agreements		1,275,000
Employee wellness program grants		1,545,100
School health curriculum		2,000,000
Smoking prevention program		2,880,000
COMMUNITY LIVING, CHILDREN, AND FAMILIES		
Adolescent health care services		1,358,000
Family planning local agreements		1,230,300
Family support subsidy		7,006,900
Local MCH services		246,100
Pregnancy prevention program		2,511,800
Prenatal care outreach and service delivery support		3,190,000
CHILDREN'S SPECIAL HEALTH CARE SERVICES		
Case management services		1,433,200
MEDICAL SERVICES		
Indigent medical program		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
Health plan services		54,575,700
OFFICE OF SERVICES TO THE AGING		
Community services		13,681,400
Nutrition services		12,363,000
Senior volunteer services		3,845,300
Michigan emergency pharmaceutical program		140,000
Respite care program		3,500,000
CRIME VICTIMS SERVICES COMMISSION		
Crime victims' rights services grants		3,400,000
TOTAL OF PAYMENTS TO LOCAL UNITS OF GOVERNMENT	$	1,066,782,700

(2) If it appears to the principal executive officer of a department or branch that state spending to local units of government will be less than the amount that was projected to be expended under subsection (1), the principal executive officer shall immediately give notice of the approximate shortfall to the state budget director.

Expenditures and funding sources subject to §§18.1101 to 18.1594.

Sec. 202. The expenditures and funding sources authorized under this act are subject to the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

State as custodian or agent.

Sec. 203. Funds for which the state is acting as the custodian or agent are not subject to annual appropriation.

Definitions.

Sec. 204. As used in this act:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "CMH" means community mental health.

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

(f) "DSH" means disproportionate share hospital.

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

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

(i) "GME" means graduate medical education.

(j) "HIV" means human immunodeficiency virus.

(k) "HMO" means health maintenance organization.

(*l*) "IDEA" means individuals with disabilities education act.

(m) "IDG" means interdepartmental grant.

(n) "IDT" means intradepartmental transfer.

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

(p) "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.

(q) "Title X" means title X of the public health services act, 300 U.S.C. 1001.

(r) "Title XVIII" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(s) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396d, 1396f to 1396g, and 1396i to 1396s.

(t) "Title XX" means title XX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1397 to 1397f.

Hiring freeze; exceptions.

Sec. 206. (1) Beginning October 1, 1998, there is a hiring freeze 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 the state department or agency being 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 appropriations committees the number of exclusions to the hiring freeze approved during the previous month and the justification for the exclusion.

Fees and collections; carrying forward revenue; use.

Sec. 207. If the revenue collected by the department from fees and collections exceeds the amount appropriated in part 1, the revenue may be carried forward 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.

Billing received from contractor or service provider; receipt more than 12 months from provided service.

Sec. 208. Except as provided in section 111b(11) of the social welfare act, 1939 PA 280, MCL 400.111b, relative to medical services providers, the department shall not pay for a billing received from a contractor or service provider that is submitted more than 12 months after the bill for a good or service is provided.

Amounts supported with federal maternal and child health, preventive health and health services, substance abuse block grant, healthy Michigan fund, and Michigan health initiative funds.

Sec. 209. (1) From the amounts appropriated in part 1, no greater than the following amounts are supported with federal maternal and child health, preventive health and health services, substance abuse block grant, healthy Michigan fund, and Michigan health initiative funds:

(a) Maternal and child health block grant	$	20,552,000.
(b) Preventive health and health services block grant		4,982,300.
(c) Substance abuse block grant		62,857,700.
(d) Healthy Michigan funds		44,768,100.
(e) Michigan health initiative		9,600,000.

(2) On or before February 1, 1999, the department shall report to the house 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 1999-2000 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 1999-2000 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.

State departments, agencies, and commissions receiving tobacco tax funds; report.

Sec. 210. The state departments, agencies, and commissions receiving tobacco tax funds from part 1 shall report by October 1, 1998, to the senate and house 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 deemed necessary by the house or senate appropriations committees or the state budget director.

State restricted tobacco tax revenue; use; prohibition.

Sec. 211. 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.

Billing by department of civil service.

Sec. 212. The department of civil service shall bill departments and/or agencies at the end of the first fiscal quarter for the 1% charges 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.

List of available reports; distribution; request for copies.

Sec. 213. On October 1, 1998 and April 1, 1999, the department shall make a list available of reports to be prepared pursuant to the provisions of this act. The list shall be distributed to house and senate appropriations subcommittees on community health, house and senate fiscal agencies, house and senate central staffs, and the state budget director. The listed parties may request copies of reports from the list and submit the request back to the department. The department shall provide copies of the requested reports no later than the date the report is due to those persons requesting the reports.

Arab-American and Chaldean council and ACCESS primary care services.

Sec. 214. The source of funding for the part 1 appropriation for the Arab-American and Chaldean council, and ACCESS primary care services is the federal preventive health and health services block grant.

Accounts receivable, deferrals, and prior year obligations; write-offs; report.

Sec. 215. (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 1998-99, but shall also include reimbursements, refunds, adjustments, and settlements from prior years.

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

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

Sec. 216. (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, for the department.

(2) The director shall strongly encourage firms with which the department contracts to subcontract with certified businesses in depressed and deprived communities for services or supplies, or both.

Purchase of foreign goods or services.

Sec. 217. Funds appropriated in part 1 shall not be used for the purchase of foreign goods and/or services when competitively priced and of comparable quality American goods and/or services are available.

Medicaid managed mental health care services; progress report.

Sec. 218. The department shall provide a report on the progress of Medicaid managed mental health services to the members of the senate and house appropriations subcommittees on community health, the senate committee on families, mental health, and human services, and the house committee on mental health by September 30, 1999. The report shall summarize actions taken by the department community mental health services programs and substance abuse coordinating agency networks to implement these specialized managed care programs, and shall include summary information on inpatient and partial hospitalization and costs, access to services, and summary information on consumer satisfaction measures.

Changing department computer software and hardware; progress billings.

Sec. 220. (1) The department shall submit to the department of management and budget, the house and senate appropriations committees, the house and senate fiscal agencies and the house and senate standing committees having jurisdiction over technology issues, quarterly reports on the department's efforts to change the department's computer software and hardware as necessary to perform properly in the year 2000 and beyond. These reports shall identify actual progress in comparison to the department's approved work plan for these efforts. These reports also shall identify and forward as appropriate the funding sources that should support the work performed.

(2) The department may present progress billings to the department of management and budget for the costs incurred in changing computer software and hardware as necessary to perform properly in the year 2000 and beyond. At the time progress billings are presented for reimbursement, the department shall identify and forward as appropriate the funding sources that should support the work performed.

Contingency funds; availability for expenditure.

Sec. 222. (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 pursuant to 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 $10,000,000.00 for state restricted contingency funds. These funds are not available for expenditure until they have been transferred to another line item in this act pursuant to 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 $10,000,000.00 for local contingency funds. These funds are not available for expenditure until they have been transferred to another line item in this act pursuant to 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 pursuant to section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

Basic health services for purpose of §§333.2301 to 333.2321.

Sec. 223. Basic health services for the fiscal year beginning October 1, 1998, for the purpose of part 23 of the public health code, 1978 PA 368, MCL 333.2301 to 333.2321, are those described by the department in its proposed program statement dated October 16, 1981, and in the "prenatal postpartum care, proposed basic health service program statement" included in the department document entitled "A Study of Prenatal Care as a Basic Service," dated March 1, 1986, and for which the legislature has made funds available in amounts necessary to ensure their availability and accessibility. The services described in the statement are: immunizations, communicable disease control, venereal disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, screening newborns for phenylketonuria, screening newborns for hypothyroidism, health/medical annex of emergency preparedness plan, licensing and surveillance of agricultural labor camps, and prenatal care.

Projects and activities prescribed in §333.2611; contract with Michigan public health institute; reports.

Sec. 224. 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 for up to a 3-year period to carry out these purposes. The department shall report on projects to be carried out by the institute, expected project duration, and project cost by November 1, 1998 and May 1, 1999 to the house and senate appropriations subcommittees on community health, senate and house fiscal agencies, and the state budget director. If the reports are not received by the specified dates, no funds shall be disbursed. For the purposes of this section, the Michigan public health institute shall be considered a public health agency.

Dangers of radon gas; media activities.

Sec. 225. No funds appropriated in part 1 shall be expended for media activities regarding the alleged dangers of naturally occurring radon gas.

Pathological gambling addictions; programs for education, research, and treatment services.

Sec. 227. The department may receive and expend funds dedicated to the establishment of programs for education, research and treatment services related to pathological gambling addictions.

Consolidated line items; report on budget detail.

Sec. 228. By November 1, 1998, the department shall report to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director the budget detail for the line items that have been consolidated in the fiscal year 1998-99 appropriation bill. The budget detail shall include the amounts allocated for program elements that correspond to the line items as contained in the fiscal year 1997-98 appropriation bill as well as planned allocations to local agencies by program element. On a quarterly basis, the department shall report expenditures in the same format as the budgeted detail, and provide copies of any allocation changes made during the course of the fiscal year.

Reports; receipt and retention of copies.

Sec. 229. The department shall receive and retain copies of all reports funded from the appropriations in part 1.

Personal service contracts; reports; listing.

Sec. 230. (1) The department of management and budget and each principal executive department and agency shall provide to the senate and house of representatives standing committees on appropriations and the senate and house fiscal agencies a monthly report on all personal service contracts awarded without competitive bidding, pricing, or rate-setting. The notification shall include all of the following:

(a) The total dollar amount of the contract.

(b) The duration of the contract.

(c) The name of the vendor.

(d) The type of service to be provided.

(2) For personal service contracts of $100,000.00 or more, the department of management and budget shall provide a monthly report including all of the following:

(a) The total dollar amount of the contract.

(b) The duration of the contract.

(c) The name of the vendor.

(d) The type of service to be provided.

(3) The department of management and budget shall provide a monthly listing of all bid requests or requests for proposal that were issued.

(4) Each principal executive department and agency shall provide a monthly summary listing of information that identifies any authorizations for personal service contracts that are provided to the department of civil service pursuant to delegated authority granted to each principal executive department and agency related to personal service contracts.

Capped federal funds, special revenue funds, and accounting; report.

Sec. 231. Within 10 working days after formal presentation of the executive budget, the state budget director shall report to the members of the senate and house appropriations committees and the senate and house fiscal agencies on the amounts and sources of all capped federal funds, special revenue funds as defined in the state of Michigan's comprehensive annual financial report, and the healthy Michigan fund, and an accounting of the state departments or agencies in which the executive budget proposes to spend the funds.

Privatization; project plan.

Sec. 232. Sixty days before beginning any effort to privatize, the department shall submit a complete project plan to the appropriate house and senate appropriations subcommittees and the house and senate 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 house and senate appropriations subcommittees and the house and senate fiscal agencies within 30 months.

Personal services contract with temporary service agency hiring retired state employee; limitation.

Sec. 233. If a department enters into a personal services contract with any temporary service agency or similar contractor that hires or subcontracts with a person who retired from employment in the department under the early retirement program under section 19f of the state employees' retirement act, 1943 PA 240, MCL 38.19f, the retired state employee shall be limited to 500 hours for professional, technical, or clerical services and 250 hours for management services. This limitation does not apply to computer technology services. This provision only applies during a 24-month period after the date of retirement. This section applies to each principal executive department and agency.

Medicaid and non-Medicaid service providers; waiting lists; report.

Sec. 235. The department shall require that providers of Medicaid and non-Medicaid services, such as nursing home providers, community mental health service programs, and other health related services, maintain waiting lists for service needs not met, preserving the confidentiality of clients as required by law. The waiting lists shall include data by type of service and provide an average length of time persons have been waiting for services. No later than April 1, 1999, the department shall provide a report on the information required by this section to the members of the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

DEPARTMENTWIDE ADMINISTRATION

Returning employees under limited duty assignments.

Sec. 302. From funds appropriated for worker's compensation, the department may make payments in lieu of worker's compensation payments for wage/salary and related fringe benefits for employees who return to work under limited duty assignments. Employees returning to work under limited duty assignments who are funded under this section will be in addition to the facility's existing staffing authorization.

Community health advisory council; member per diems and other expenditures.

Sec. 303. 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.

Revenue and expenditure status; reports.

Sec. 305. The department shall provide quarterly reports concerning the department's revenue and expenditure status to the senate and house appropriations committees, the house and senate fiscal agencies, and the state budget director.

First-party payment for mental health services; limitation.

Sec. 309. The department is prohibited from requiring first-party payment from individuals or families with a taxable income of $9,000.00 or less for mental health services.

Federal, state restricted, local, private, and CMHSP-purchase of state contracts; restricted revenue.

Sec. 310. The specific amounts indicated in sections 103, 104, and 105 of this act as restricted revenue for financing appropriations from federal, state restricted, local, private, and CMHSP - purchase of state services contracts are estimates of the proportion of the total amounts expected to be collected, and the department may satisfy any individual restricted revenue deduct amount from the total revenues of all of those revenue sources. A report shall be provided by April 15 to the fiscal agencies and the state budget director on actual collections by revenue source for each appropriation unit during the previous fiscal year.

Medicare rural hospital flexibility program; application for funding.

Sec. 311. The department shall make application for funding under the medicare rural hospital flexibility program for planning, network development and critical access hospital designation activities.

Reimbursement for psychiatric services; Medicaid waiver from prohibition; request.

Sec. 312. The department shall seek a Medicaid waiver from the requirement that prohibits reimbursement for psychiatric services to persons between the ages of 21 and 65 provided by institutions for mental disease. The waiver request shall be for both public and private hospitals providing such services. A copy of the federal waiver request shall be provided to the house and senate appropriations subcommittees on community health, and to the house and senate fiscal agencies at the time of submission.

Community-based collaborative prevention services.

Sec. 313. In implementing appropriated services pursuant to the pilot projects in prevention for adults and children and the maternal and child health outreach and advocacy program line items, 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.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Community living arrangement; contract for legal services; prohibition.

Sec. 350. The department shall not enter into new contracts with private attorneys for legal services for the purposes of gaining and maintaining occupancy to a community living arrangement. 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. State funds shall not be used for legal services to represent private investors purchasing homes for these purposes.

Community residential programs; use of funds for basic care.

Sec. 351. The funds appropriated in part 1 for community residential services programs may be used for basic care in cases where individuals are not eligible to receive social security benefits and are not otherwise capable of supporting themselves out of their own resources. Funds may be used for aftercare services or to prevent admissions to state hospitals and centers through residential and support services. Expenditures and allocations may be authorized for CMHSPs and state hospitals, centers, and placement agencies.

Sec. 352. Five hundred thousand dollars is appropriated in part 1 from the healthy Michigan fund to the agency designated by the governor pursuant to section 931 of the mental health code, 1974 PA 258, MCL 330.1931, for the purpose of providing protection and advocacy services for individuals with substance abuse disorders. The agency shall provide information and referral services, written materials for consumers, and monitoring of facilities providing care or treatment and investigate complaints. Evaluation of substance abuse services provided by the department of corrections shall be provided by this agency in cooperation with other entities.

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

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Comprehensive community mental health services; authority and responsibility of local CMHSPs; single entry and exit; written agreement required for alteration or modification of contract.

Sec. 401. (1) Funds appropriated in section 104 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.

Execution of contracts; final authorizations to CMHSPs; funds provided to state hospitals, centers, and placement agencies; billing and collection procedures; access to funds; increased costs.

Sec. 402. (1) From funds appropriated in section 104, 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.

(2) The funds appropriated in section 104 for the purchase of state service contracts are for the purchase of state hospital and center services, or for approved community-based programs that reduce utilization of state provided services. These funds shall be authorized to CMHSPs based on estimates approved by the department as part of the negotiated contract.

(3) Funds that are authorized to CMHSPs, when used to purchase state services, shall be provided to state hospitals, centers, and placement agencies based on the per diem and billing arrangements approved by the department in the negotiated contract.

(4) Current billing and collection procedures for the net cost of state provided services shall continue as specified in chapter 3 of the mental health code, 1974 PA 258, MCL 330.1302 to 330.1320.

(5) The department may access funds from the appropriation directly for patients who have no county affiliation or for whom county charges are exempted.

(6) The funds appropriated in section 104 from purchase of state service contracts shall not result in increased costs to counties in excess of the local match required under section 302 and section 308 of the mental health code, 1974 PA 258, MCL 330.1302 and 330.1308.

CMHSP services and community demand; carrying forward reserved funds.

Sec. 405. Funds appropriated in part 1 for CMHSP services and community demand may be reserved and carried forward pursuant to provisions in the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

Multicultural special needs projects.

Sec. 406. From the funds appropriated for CMHSP, $3,360,000.00 will be directed toward providing multicultural special needs projects.

Community mental health services programs; report.

Sec. 407. (1) Not later than April 10 of each fiscal year, the department shall provide a report on the community mental health services programs to the members of the house 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. This report will be updated to the extent possible, based on available data, by September 30.

(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:

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

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

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

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

Community mental health services programs; report on data from fiscal year 1997-98.

Sec. 408. (1) By April 10, 1999, the department shall report the following data from fiscal year 1997-98 on community mental health services programs to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director:

(a) An estimate of the number of FTEs employed or contracted directly by the CMHSPs as of September 30, 1998 and an estimate of the number of FTEs employed through contracts with provider organizations as of September 30, 1998.

(b) Lapses and carryforwards for CMHSPs, including historical lapse and carry-forward data.

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

(2) The department shall include these data reporting requirements in the annual contract with individual CMHSPs.

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

(4) Agencies contracting with CMHSPs shall provide 3 days' notice to the CMHSP of all committee and full board meetings and shall conduct all portions of meetings pertaining to CMHSPs funded programs in the same manner as required for meetings of public bodies under the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

Workers in residential services settings; employee wage pass-through; availability of pool of funds.

Sec. 409. (1) The 75 cents per hour per employee wage pass-through for workers in residential services settings that was funded to CMHSPs beginning January 1, 1998, shall continue to be paid to direct care workers in fiscal year 1998-99.

(2) From the funds appropriated in part 1 for community mental health services programs, money shall be utilized to establish a pool of funds available to local community mental health services programs, sufficient to provide for increasing the wages and the employer's share of federal insurance contributions act costs of direct care staff by 50 cents per hour per direct care worker in local residential settings and for paraprofessional and other nonprofessional direct care workers in day programs, supported employment, and other vocational service programs, effective April 1, 1999.

(3) From the funds appropriated in part 1 for community mental health services programs, money shall be utilized to establish a pool of funds available to local community mental health services programs, sufficient to provide for increasing the wages of direct care staff by 25 cents per hour for paraprofessional and other nonprofessional direct care workers in day programs, supported employment, and other vocational service programs, effective April 1, 1999.

(4) Each CMHSP may make application to the department to receive funds for the direct care worker wage pass-through fund, not to exceed their proportionate share of the money allocated for this purpose. The application shall specify the amount of funds requested and the agencies/programs to receive the wage pass-through funds requested.

(5) Each CMHSP awarded wage pass-through funds shall report on the actual expenditures of such funds in the format to be determined by the department. Any funds not utilized by the CMHSP for the purpose specified in the wage pass-through application shall be deducted from the base allocation to the CMHSP in the subsequent fiscal year.

Purchase of service residential contracts; administrative costs in excess of previous levels; annual report.

Sec. 410. The department shall take steps to ensure that the administrative costs of purchase of service residential contracts do not exceed previous levels. The department shall report annually to the house and senate appropriations subcommittees on community health information about administrative and other provider costs.

State disability assistance substance abuse services program; use of funds; eligibility; reimbursement.

Sec. 411. (1) The funds appropriated in section 104 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.

Substance abuse prevention, education, and treatment grants; fee schedule.

Sec. 412. (1) The amount appropriated in section 104 for substance abuse prevention, education, and treatment grants shall be expended for contracting with coordinating agencies or designated service providers.

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

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

Sec. 413. (1) By April 15, 1999, the department shall report the following data from fiscal year 1997-98 on substance abuse prevention, education, and treatment programs to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies:

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

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

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

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

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

Substance abuse services; distribution of funding; priority.

Sec. 414. The funding in section 104 for substance abuse services shall be distributed in a manner so as to provide priority to service providers which furnish child care services to clients with children.

Odyssey House residential substance abuse treatment program; allocation.

Sec. 415. If the state's fiscal year 1998-99 federal block grant allocation for substance abuse services is increased by $1,900,000.00 or more from the prior fiscal year and federal funding is not awarded to the Odyssey House residential substance abuse treatment program, the department shall allocate no less than $1,900,000.00 to the Odyssey House residential substance abuse treatment program.

Existing and new substance abuse funding; utilization, amount, and impact.

Sec. 416. By September 30, 1999, the department shall report to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies on how the existing and new substance abuse funding was utilized, the amount of services provided, and their impact on reducing substance abuse problems.

Priority positions granted under federal block grant.

Sec. 418. If a person licensed to provide substance abuse services receives federal substance abuse prevention block grant funds, any priority positions established under state statute for recipients of their services shall apply only after serving those priority positions granted under the conditions of the federal block grant.

Consumer grievance and appeal rights and protections; assurance of access.

Sec. 419. The department shall require that CMHSPs assure access to the consumer grievance and appeal rights and protections contained in the signed fiscal year 1998-99 DCH-CMHSP contract for managed specialty supports and services, including the grievance and appeal technical requirement labeled attachment 4.7.4.1 effective October 1, 1998.

Applicants and recipients of public assistance; substance abuse treatment as condition of eligibility.

Sec. 421. 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 incarceration; diversion services.

Sec. 422. (1) The department shall ensure that each contract with a CMHSP shall require the CMHSP to implement programs to encourage diversions 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.

Salvation Army harbor light program; substance abuse services; contract.

Sec. 423. The department shall contract directly with the Salvation Army harbor light program for the provision of substance abuse services at not less than the amount provided in fiscal year 1997-1998.

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

Third-party payments for services; priority; 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 which 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.

Telephone revenues and gifts and bequests for patient living and treatment environments; carrying forward unexpended and unencumbered amounts; use of funds.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $2,000,000.00 remaining on September 30, 1999 from pay telephone revenues and the amounts appropriated in section 105 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 with department of corrections; funds.

Sec. 603. The funds appropriated in section 105 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 section 105 to fulfill the obligations outlined in the interdepartmental agreements.

Hospitals and centers; authorization of FTEs and funds; retention of available funds.

Sec. 604. (1) Subject to the funds appropriated in section 105 for hospitals and centers, the department shall authorize FTEs and funds to each hospital and center on the basis of the actual utilization of each of the hospitals and centers.

(2) Funds that become available as a result of reductions in the utilization of state-operated hospitals and centers are intended to be retained by CMHSPs to support community-based services.

Closures or consolidations of state hospitals, centers, or agencies; conditions; closure plan; transfer of remaining fund balances.

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 which 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 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.

Services provided; array; scope; availability; placement; discrimination prohibited.

Sec. 606. (1) The department, in conjunction with the CMHSPs, will continue to assure the provision of a complete array of services on a statewide basis. Such an array of services shall include, but is not limited to, residential and other individualized living arrangements, outpatient services, acute inpatient services, and long-term, 24-hour inpatient care in a structured, secure environment.

(2) Long-term psychiatric beds, whether occupied or unoccupied, whether operated by the state or an agency with whom the department or a CMHSP contracts, will be available at various locations across the state.

(3) The department and CMHSPs shall continue to develop and facilitate community placement opportunities for persons with developmental disabilities, adults with mental illness, and children with emotional disturbance for whom such placement is clinically appropriate.

(4) The department and CMHSPs shall not discriminate against the placement of an individual in a state psychiatric hospital when long-term psychiatric inpatient care is appropriate. This subsection does not prohibit the department and CMHSPs from considering consumer choice, quality of care, and cost of care in making the hospital referral.

PUBLIC HEALTH ADMINISTRATION

Sale of vital records death data; use of revenue; reversion; report.

Sec. 701. Of the amount appropriated in section 106 from revenues from fees and collections, not more than $250,000.00 received from the sale of vital records death data shall be used for improvements in the vital records and health statistics program. The amount described in this section shall not revert to the general fund at the end of the fiscal year ending September 30, 1999. Not later than December 1, 1999, the amount of any unexpended balances and the proposed uses for those balances shall be reported to the senate and house fiscal agencies.

INFECTIOUS DISEASE CONTROL

Immunization; unavailability of federal funds.

Sec. 801. State funds appropriated in any other account in part 1 may be used to supplant not more than $350,000.00 in federal funds projected for immunization, if the federal funds are unavailable. The department shall inform the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director of the specific line items reduced pursuant to this section.

AIDS programs; prevention, education, and outreach services for adolescents; priority.

Sec. 802. In the expenditure of funds appropriated in section 107 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 for development and implementation.

Sec. 803. In developing and implementing AIDS provider education activities, the department may provide funding to the Michigan state medical society to continue 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.

Exposure to prisoner's blood or bodily fluid; informing employee of results of HIV test.

Sec. 804. If an employee of the department of corrections comes in contact with a prisoner and that contact involves the risk of exposure to the prisoner's blood or bodily fluids, upon the employee's request the department of corrections shall inform the employee of the results of the prisoner's HIV test if known by the department.

Hepatitis A vaccination; pilot project.

Sec. 807. From the funds appropriated in part 1, $100,000.00 shall be used to support a pilot project to vaccinate 2-year-old children countywide with hepatitis A vaccine, for the prevention of future outbreaks of hepatitis A in Calhoun County.

AIDS drug assistance program.

Sec. 808. From the funds appropriated in part 1 for AIDS prevention, testing, and care programs, the department shall continue the AIDS drug assistance program at no less than the fiscal year 1997-98 eligibility criteria and drug formulary.

Allocation to hepatitis B vaccine program; purpose.

Sec. 809. Of the funds appropriated in part 1, $4,600,000.00 from the sexually transmitted disease control local agreements line shall be allocated to the hepatitis B vaccine program for the purpose of testing and vaccination of individuals attending sexually transmitted disease, family planning, and adolescent health clinics in an effort to reduce the spread of hepatitis B, and for administration of the program by the local clinics.

LOCAL HEALTH ADMINISTRATION AND GRANTS

Implementation of sections of public health code; reimbursement to local health departments.

Sec. 903. The amount appropriated in section 110 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.

Local public health infrastructure; reduced allocation to county.

Sec. 905. If a county receiving funding from the amount appropriated in section 110 for local public health infrastructure is part of a district health department or in an associated arrangement with other local health departments on June 1, 1992 and then ceases to be part of such an arrangement, the allocation to that county from the local public health infrastructure appropriation shall be reduced by 50% from the amount originally allocated.

Lead abatement program; report on expenditures and activities.

Sec. 908. The department shall provide a report quarterly to the house 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 not be 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; prospective allocation of funds; contractual standards; distributions; report; full expenditure.

Sec. 909. (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 diseases, hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management.

(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 1998-99 of at least the amount expended in fiscal year 1992-93 for cost shared services.

(4) By April 1, 1999, the department shall report to the senate and house appropriation 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 1998-99.

Lead abatement project sites; compliance.

Sec. 910. The department shall ensure compliance with applicable state certification requirements and protection of the workers and public health and safety at lead abatement project sites for which the department receives written notice of lead-based paint abatement activity.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Health promotion media activities; increased funds allocation for breast, cervical, and prostate cancer; use of excess funds for prostate cancer prevention programs.

Sec. 1001. (1) From the state funds appropriated in section 111, the department shall allocate funds to promote awareness, education, and early detection of breast, cervical, and prostate 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 1996-97.

(3) Any excess funds not authorized or allocated in the cancer prevention and control line item in part 1 shall be utilized for prostate cancer prevention programs.

School health education curriculum; state steering committee; content of course curriculum; examination of textbooks and other classroom materials.

Sec. 1002. (1) The amount appropriated in section 111 for school health and education programs shall be allocated in 1998-99 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; use of funds.

Sec. 1003. Funds appropriated in section 111 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 and cancer demonstration projects.

Sec. 1004. From the amounts appropriated in section 111 for the cancer prevention and control program, the department shall allocate funds to the Hurley and Harper hospitals' prostate cancer demonstration projects in fiscal year 1998-99.

Michigan physical fitness and sports foundation; contingent allocation.

Sec. 1005. From the funds appropriated in section 111 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 for pregnant women, women with young children, and adolescents.

Sec. 1006. In spending the funds appropriated in section 111 for the smoking prevention program, priority shall be given to prevention and smoking cessation programs for pregnant women, women with young children, and adolescents.

Violence prevention.

Sec. 1007. (1) The funds appropriated in section 111 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 section 111 for violence prevention, the department may include local school districts as recipients of the funds for family violence prevention programs.

Karmanos cancer institute/Wayne State University, Michigan interactive health kiosk/University of Michigan, and Michigan State University; allocations for cancer prevention activities; report.

Sec. 1008. (1) From the amount appropriated in section 111 for the cancer prevention and control program, funds shall be allocated to the Karmanos cancer institute/Wayne State University, to the Michigan interactive health kiosk/University of Michigan, and to Michigan State University for cancer prevention activities.

(2) The department shall provide a report to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies by January 1, 1999, on how these funds were allocated and spent in fiscal year 1997-98. Also, the report shall detail outcomes resulting from the use of such funds.

Kidney disease prevention programming; allocation to national kidney foundation of Michigan.

Sec. 1009. From the funds appropriated in section 111 for diabetes local agreements, 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. 1011. Of the funds appropriated in section 111 for the health education, promotion, and research programs, the department shall allocate $650,000.00 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.

Allocation for improving health of African-American men in Michigan.

Sec. 1012. From the funds appropriated in part 1 for diabetes local agreements, $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.

COMMUNITY LIVING, CHILDREN, AND FAMILIES

Distribution of funds to local health departments and other public and private agencies; reallocation of projected underexpenditures.

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.

Adolescent health care services; funding criteria; recommendations for services rendered in public school building; report.

Sec. 1102. (1) Agencies receiving funds appropriated from section 112 for adolescent health care services shall meet all of the following criteria:

(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.

(*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) Require each local school board funded by the agency to establish 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. All advisory committee meetings shall be open to the public with at least a 1-week notice of the meeting date published in the local newspaper.

(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) If a local advisory committee established under subdivision (b) recommends that family planning be provided as a service, require that any public information brochure include family planning in its description of the entire array of services provided by the adolescent health clinic.

(e) 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 fiscal agencies based on the information provided under subsection (1)(a). The report is due 90 days after the end of the calendar year.

Allocations to teen centers; formula.

Sec. 1103. Of the funds appropriated in section 112 for adolescent health care services, $1,840,830.00 shall be allocated to teen centers as follows: $90,000.00 base funding, and of the remaining funding 25% distributed on the number of users, 50% distributed on the number of visits, and 25% distributed on the number of services. This formula does not apply to the alternative models.

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

Sec. 1104. Before April 1, 1999, the department shall submit a report to the house and senate fiscal agencies on planned allocations from the amounts appropriated in section 112 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) Basis for grantee selection.

(c) Expected cost per client served by grantee.

(d) Number of women, children, and/or adolescents expected to be served.

(e) Expected first- and third-party collections by source of payment.

(f) The extent to which grantees meet federal indicators, when applicable.

(g) Actual numbers served and amounts expended in the categories described in subdivisions (a) to (e) for the fiscal year 1997-98.

Contracts with local public and private nonprofit agencies; factors for evaluation of agencies.

Sec. 1105. For all programs for which an appropriation is made in section 112, the department shall contract with those local public and private nonprofit 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, where applicable.

Family planning program receiving federal title X family planning funds; compliance with performance and quality assurance indicators.

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

Prenatal care outreach and service delivery support; expenditure; limitation.

Sec. 1107. Of the amount appropriated in section 112 for prenatal care outreach and service delivery support, not more than 10% shall be expended for local administration, data processing, and evaluation.

Teen sexual activity, teenage pregnancy, and sexually transmitted diseases.

Sec. 1109. The department shall maintain comprehensive health care programs to communicate to preteens the importance of delaying sexual activity and to address teen sexual activity, teenage pregnancy, and sexually transmitted diseases.

Abortion counseling, referrals, or services; use of funds prohibited.

Sec. 1110. The funds appropriated in section 112 for pregnancy prevention programs shall not be used to provide abortion counseling, referrals, or services.

Volunteer dental program; allocation to Michigan dental association; report.

Sec. 1111. (1) From the amounts appropriated in section 112 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 1996-97.

(2) Not later than November 1, 1998, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house standing committees on public health the number of individual patients treated, the number of procedures performed, and approximate total market value of those procedures through September 30, 1998.

Receipt of family planning funds by agencies; designation as delegate agencies.

Sec. 1113. 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.

Direct provision of family planning/pregnancy prevention services.

Sec. 1114. The department shall allocate no less than 86% of the funds appropriated in section 112 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; allocations.

Sec. 1117. 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.

Neonatal addiction and fetal syndrome.

Sec. 1118. From the funds appropriated in part 1, the department shall allocate no less than $200,000.00 to provide education and outreach to targeted populations on the dangers of 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.

Sec. 1119. In addition to the amounts appropriated in part 1 for the family support subsidy, there shall be appropriated $10,000,000.00 from the general fund to the family support subsidy line item if House Bill No. 4753 of the 89th Legislature is enacted into law.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

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

Sec. 1201. Money appropriated in section 113 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.

Services provided to department.

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

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

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

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

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

Children's special health care services program; 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.

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

OFFICE OF DRUG CONTROL POLICY

Office of drug control policy; service as coordinating office; distribution of funds.

Sec. 1250. The purpose of the office of drug control policy is to serve as coordinating office for all agencies of the executive branch of government which are responsible for drug-abuse prevention, drug-abuse treatment, and drug law enforcement and to develop a state drug-abuse prevention, drug-abuse treatment, and drug law enforcement plan. The office of drug control policy shall receive, administer, and distribute funds received by the office of drug control policy under or through titles III and VI of the federal anti-drug abuse act.

Federal safe and drug free schools program; approval of grants; deadline date.

Sec. 1251. The office of drug control policy is required to approve grants for the federal safe and drug free schools program within 90 days from the grant application submission deadline date.

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

Eligibility restriction.

Sec. 1401. The appropriation in section 116 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.

Receipt and expenditure of funds; additional purposes; publications, videos, and related materials; 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 section 116 for the additional purposes described in this section.

(2) The office of services to the aging may establish and collect fees for publications, videos, and related materials. Collected fees shall be used to pay for the printing and mailing costs of the publications, videos, and related materials, which costs shall not exceed the revenues collected.

(3) Money appropriated in section 116 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 services; Medicaid funds.

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

Statewide care management or case coordination projects; regions; report.

Sec. 1406. (1) Of the amount appropriated in section 116 to the office of services to the aging for community services, sufficient funds shall be allocated to fund statewide care management or case coordination projects in the following regions:

Region 1A	$	903,700
Region 1B		1,084,400
Region 1C		632,600
Region 2		271,100
Region 3		451,900
Region 4		271,100
Region 5		451,900
Region 6		271,100
Region 7		542,200
Region 8		542,200
Region 9		542,200
Region 10		542,200
Region 11		542,200
Region 14		271,100

(2) The office of services to the aging shall provide a report to the senate and house appropriations subcommittees on community health, and the senate and house fiscal agencies by November 1, 1998, summarizing the accomplishments of each program in the 1997-98 fiscal year.

Contract awards and funds distribution.

Sec. 1407. 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.

Local awards.

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.

In-home services for seniors.

Sec. 1409. From the additional funds appropriated in the community services line, a total of $200,000.00 shall be used for providing in-home services for seniors.

Sec. 1410. (1) The department shall increase annual funding for the long-term care ombudsman program by no less than $40,000.00.

(2) By October 15, 1998, the department shall award no less than an 18-month contract for the long-term care ombudsman program.

MEDICAL SERVICES ADMINISTRATION

Loan repayment for dentists.

Sec. 1501. The funds appropriated in section 117 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.

Sec. 1502. The department is directed to continue support of multicultural agencies which provide primary care services from the funds appropriated in section 117.

MEDICAL SERVICES

Medical care services; grievance review procedure; payment of settlements.

Sec. 1601. The department of community health shall provide an administrative procedure for the review of 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; reimbursement; limitation; payment in full; hospital services provided to dual Medicare/medical services.

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 deemed 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.

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

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

Pharmaceutical dispensing fee; copayments on services; waiver; usual and customary charges.

Sec. 1603. (1) Effective October 1, 1998, the pharmaceutical dispensing fee shall be $3.72 or the usual and customary cash charge, whichever is less. If a recipient is 21 years of age or older, the department shall require a $1.00 per prescription client copayment, except as prohibited by federal or state law or regulation.

(2) The department shall require copayments on dental, podiatric, chiropractic, vision, and hearing aid services provided to recipients of medical assistance except as excluded by law.

(3) The copayments in subsections (1) and (2) may be waived for recipients who participate in a program of medical case management such as enrollment in a health maintenance organization or the primary physician sponsor plan program.

(4) Usual and customary charges for pharmacy providers are defined as the pharmacy's charges to the general public for like or similar services.

Remedial services.

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 means those services which produce the maximum reduction of physical and mental limitations and restoration of an individual to his or her best functional level. At a minimum, remedial services include basic self-care and rehabilitation training for a resident.

Medicaid adult dental services, podiatric services, and chiropractic services; utilization limitations and restrictions.

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.

Basic health care needs of indigent persons; program; establishment; eligibility; enrollment application; services; nursing facility coverage.

Sec. 1609. (1) From the funds appropriated in section 118 for the indigent medical care program, the department shall establish a program which 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 system; psychiatric services; specialty mental health, substance abuse, and developmental disabilities.

Sec. 1610. (1) The department may require medical services recipients to receive psychiatric services through a managed care system.

(2) The department may implement managed care programs for specialty mental health, substance abuse, and developmental disabilities services. Such programs shall be operated through CMHSPs and substance abuse coordinating agencies as specialty service carve-outs to maintain accountability for the system to local units of government and to preserve the services and supports for persons with severe and persistent mental illnesses, for persons with substance abuse addictions, and for persons with developmental disabilities.

(3) The substance abuse coordinating agencies shall arrange for clinical reviews to assure appropriate continuity of care for recipients of substance abuse treatment services.

Managed care; preference; assignment; criteria for medical exceptions; basis; granting exception to mandatory enrollment.

Sec. 1611. (1) The department may continue to implement managed care and 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 30 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.

Single-source pharmaceutical products; drug utilization review and monitoring programs.

Sec. 1612. (1) The department shall not preauthorize or in any way restrict single-source pharmaceutical products except those single-source pharmaceuticals that have been subject to prior authorization by the department prior to January 1, 1992 and those single-source pharmaceuticals within the categories specified in section 1927(d)(2) of the social security act, 42 U.S.C. 1396s(d), or for the reasons delineated in section 1927(d)(3) of the social security act.

(2) The department may implement drug utilization review and monitoring programs that may cover renewals of prescriptions of anti-ulcer agents; these programs shall not be expanded to other therapeutic classes. Such programs shall have physician oversight through the drug utilization and review board to ensure proper determination.

Mail-order pharmacy program; prohibition.

Sec. 1613. The department shall not implement a mail-order pharmacy program for the noncapitated portion of the Medicaid program.

Early and periodic screening, diagnosis, and treatment services; tests for Medicaid eligible 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.

Sharing federal Medicaid services funds; agreements; authority of department; distributions; conditions.

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 department of management and budget 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 section 118 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.

(3) The department shall not make distributions from the funds provided for this purpose in section 118 until it has filed the necessary state plan amendments, made required notifications, received an indication of approval from the health care financing administration, and received approval from the state budget director.

Medical services state plan amendment; approval; increase to special adjustor appropriation.

Sec. 1616. The special adjustor appropriation in section 118 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 and receives an indication of approval of the amendment from the health care financing administration. The department is authorized to appropriately adjust financing sources in accordance with the increased appropriation.

Health plans; allocation to increase transportation per member.

Sec. 1616a. From the funds appropriated in fiscal year 1998-99 for health plan services, $8,248,700.00 gross, $3,900,000.00 general fund/general purpose shall be allocated to increase the transportation per member per month payment to qualified health plans that had submitted bids under the comprehensive health plan and signed contracts with the department before January 1, 1998.

Patient-based utilization data; annual reports.

Sec. 1617. The department of community health shall obtain from those health maintenance organizations and clinic plans with which the department contracts patient-based utilization data, including immunizations, early and periodic screenings, diagnoses, and treatments, substance abuse services, blood lead level testing, and maternal and infant support services referrals. The department shall submit annual reports on patient-based utilization data to the members of the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, the state budget director, and the director of each local health department.

Payment increases for enhanced wages.

Sec. 1618. It is the intent of the legislature that payment increases for enhanced wages shall be provided to those facilities which make application for it to fund the Medicaid program share of wage increases up to 50 cents per employee hour. The pass-through shall only be used to increase wages and the employer's share of federal insurance contributions act costs. Nursing facilities shall be required to document that these wage increases were actually provided.

Elderly and disabled persons with incomes less than or equal to poverty line; medical services.

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 of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396a.

Long-term care services; funding 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.

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

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.

Noncompliance with medical services certification; implementation of enforcement actions; receipt, expenditure, and carrying forward penalty money.

Sec. 1622. (1) The department shall implement enforcement actions as specified in the nursing facility enforcement provisions of 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.

Election of hospice services.

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.

Indigent health care programs; funding; establishment; minimum allocation.

Sec. 1626. (1) From the funds appropriated in part 1 for outpatient hospital indigent adjustor, 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 outpatient services. Such payments, if any, may be made as a gross adjustment to hospital outpatient payments or by another mechanism or schedule as determined by the department, which meets the intent of this section.

(2) For counties with populations in excess of 2,000,000 persons, the department shall distribute $44,012,800.00 to hospitals if $15,026,700.00 is received by the state from such counties, 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 these counties, 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 similar programs in additional counties 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 reports; submission by institutional provider.

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.

Buy-in of medical coverage.

Sec. 1634. (1) The department may establish a program for persons who work their way off welfare to purchase medical coverage at a rate determined by the department.

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

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

Medicaid managed care plans; conditions for implementation.

Sec. 1635. The implementation of all Medicaid managed care plans by 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) A contract for an independent evaluation is in place to measure cost, access, quality, and patient satisfaction.

(c) The department shall require contracted health plans to submit data determined necessary for the evaluation on a timely basis. A report of the independent evaluation shall be provided to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies no later than September 30, 1999.

(d) A health plans advisory council is functioning which 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.

(e) Contracts for enrollment services and beneficiary services, and the complaint/grievance procedures are in place for the geographic area and populations affected. An annual report on enrollment services and beneficiary services and recipient problems/complaints shall be provided to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies.

(f) 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.

(g) Maternal and infant support services shall continue to be provided through state-certified providers. The department shall continue to reimburse state-certified maternal and infant support services providers on a fee-for-service basis to be charged back to health plans until such time as health plans have contracts with state-certified providers.

(h) 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.

(i) The department may encourage bids for multicounty regions through the use of preference points but shall not initially require a plan provider to submit a bid for a multicounty region.

(j) Enrollment of recipients of children's special health care services in qualified health plans shall be voluntary during fiscal year 1998-99.

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:

(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 such 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 such 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 which assures continuity. Medically necessary services shall be available and accessible 24 hours a day and 7 days a week.

(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 which could not be reasonably obtained through the plan's providers on a timely basis. Such services shall be deemed 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 such 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 such 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. The department may establish alternative standards and requirements that specify financial safeguards for organizations not otherwise covered by existing law which assure that the organization has the ability to accept financial risk.

(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.

Qualified health plans; contract with organization providing quality assessment; functions.

Sec. 1638. From the funds appropriated in section 118 for health plan services, the department may contract for the assessment of quality in qualified health plans which enroll Medicaid recipients. Organizations providing such quality reviews shall meet the requirements of the department and include the following functions:

(a) Review of plan performance based on accepted quality performance criteria.

(b) Utilization of quality indicators and standards developed specifically for the Medicaid population.

(c) Promote accountability for improved plan performance.

Medicaid qualified health plans; direct marketing services prohibited; information and enrollment materials.

Sec. 1639. (1) Medicaid qualified health plans shall not directly market their services to or enroll Medicaid eligible persons. The department shall provide or arrange for assistance to Medicaid enrollees in understanding, electing, and using the managed care plans available. Upon request of the Medicaid recipient, such assistance shall be provided in person through a face-to-face interview prior to enrollment, when practicable.

(2) Information regarding the available health plans and enrollment materials shall be provided through local family independence agency offices during the eligibility determination and redetermination process, and at other locations specified by the department. The enrollment materials shall clearly explain covered services, recipient rights, grievance and appeal procedures, exception criteria to mandatory enrollment, and information regarding managed care enrollment broker and beneficiary services.

Qualified health plan; lock-in period; exceptions; changing for any reason.

Sec. 1640. (1) The department may require a 6-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 30 days of enrollment.

Qualified health plan; expedited complaint review procedure for Medicaid eligible persons; 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 where 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) Quarterly reports summarizing the problems and complaints reported and their resolution shall be provided to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the department's health plans advisory council.

Beneficiary services.

Sec. 1642. (1) The department shall require the enrollment contractor to provide beneficiary services. These services shall include:

(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.

(2) The department shall not contract for enrollment counseling services unless the contract complies with and includes provisions for all beneficiary services defined in subsection (1).

Programs providing services to medical assistance recipients; contracts; provisions; preference.

Sec. 1643. (1) The department may develop a program for providing services to medical assistance recipients under a risk sharing capitation arrangement, through contracts with provider-sponsored networks, health maintenance organizations, and other organizations. The department shall award contracts under the program at least every 5 years based on a competitive bidding process. In developing a program under this section, the department shall consult with providers, medical assistance recipients, and other interested parties. The following provisions shall be considered in any program:

(a) In determining eligible contractors, the department shall consider provider-sponsored networks, along with health maintenance organizations, and other organizations. All eligible contractors shall meet the same standards for quality, access, benefits, financial, and organizational capability.

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

(2) Whenever economical and feasible, the department shall give preference to programs that provide a choice of qualified contractors and at least an annual open enrollment in the program.

Prenatal care; eligibility.

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 such measures as may be 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 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.

(3) The department shall prepare a report analyzing the options that exist under state and federal law to expand the Medicaid protected income level, including expansion to the maximum allowed under federal law. The analysis shall include an estimate of the number of people likely to be affected and the costs associated with each option. The report shall be submitted to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies by January 1, 1999.

Guardian and conservator charges; deduction as expense for determining eligibility and amounts.

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.

Access to obstetrician-gynecologist services.

Sec. 1654. A qualified health plan that requires a Medicaid recipient to designate a participating primary care provider shall permit a female Medicaid recipient to access a participating obstetrician-gynecologist for annual "well-woman" examinations and routine obstetrical and gynecologic services. This access would not require prior authorization or referral, but may be limited by participation of obstetricians-gynecologists in the plan network. A referral to an out-of-plan physician will require plan approval.

Terminally and chronically ill individuals; program priorities.

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; establishment of working group; considerations; enrollment requirements; voluntary plan participation.

Sec. 1657. (1) The department shall develop a written long-term care plan in consultation with the legislature. The department shall establish a long-term care working group to develop the plan. The long-term care working group shall consist of 2 members of the house, 2 members of the senate, and 4 representatives of the department. Senate members shall be appointed by the senate majority leader. House members shall be appointed by the speaker of the house of representatives. The director shall appoint department representatives. The department shall consult with the long-term care industry, consumers, and other interested parties during the workgroup process. The plan shall consider the following:

(a) A budget-neutral expansion of the home and community based services (HCBs) as alternatives to nursing homes.

(b) Payment methodologies that are aligned to maintain eligible beneficiaries in the most homelike setting at reasonable cost.

(c) A budget-neutral expansion of home and community based services program to other non-nursing home settings.

(d) Coordination, to the degree possible, with the federal Medicare program.

(e) Administrative simplicity to the degree possible, while maintaining flexibility in financing and service delivery configurations, such as common claim forms and data reporting requirements.

(2) Once the plan is developed, the long-term care workgroup shall conduct public hearings in at least 5 regions of the state to obtain public comment.

(3) The department may enroll beneficiaries in a long-term care plan if the following requirements are met:

(a) An eligibility screening/enrollment component is in place at community hospitals, in-home for persons who are homebound, as well as at convenient community locations.

(b) The eligibility screening/enrollment counseling service is performed by an independent entity selected through a request for proposal.

(c) Enrollment counselor services are available to the clients and their families to ensure clients or the legally authorized representatives have the information necessary to make an informed choice of plans, to appropriately access care within the plan, to file grievances with the plan and the state, and to access care out of network if appropriate.

(d) Quality outcome measures are developed based on the minimum data sets for home care and nursing home care. The department will develop quality outcome measures that utilize Zimmerman's quality of care principles.

(e) Services offered shall include a range of home and community services including adult day care, respite care, homemaker, chore, personal care, personal care supervision, personal emergency response systems, community living supports, and services in nursing home settings.

(f) There shall be 2 long-term care plan contractors in all areas of the state except in areas with sparse population and when the long-term care plan network includes at least 85% of the LTC providers of the region.

(g) Long-term care plans are selected through a request for proposal process that identifies organizations capable of organizing and operating a continuum of services.

(h) The department reviews and approves provider contracts used by the plan to ensure that the plan's risk/incentive arrangements do not provide incentives to withhold appropriate medical services.

(i) The department establishes criteria for the plan's provider network that take into consideration the unique needs of the population to be enrolled and ensure that the network has adequate capacity to provide home and community-based service alternatives and is in place before enrollment begins.

(j) The department establishes requirements for encounter data collection and reporting that ensure the department has the ability to closely monitor care provided to enrollees to assure quality and appropriate access to care.

(k) The department contracts for an independent, external quality review of the services provided through the long-term care plans. The protocols used in the review shall be appropriate for the specialized population enrolled in the plan and shall be at least as rigorous as those used by the national committee on quality assurance.

(*l*) The department conducts annual patient satisfaction surveys using statistically valid sampling techniques that focus on this population and a survey tool that is appropriate to the population being served. These surveys shall include a resident and family experience survey for all plan members.

(m) The department maintains an expedited grievance process that provides a response to urgent requests within 1 business day.

(n) Eligibility for the long-term plan is based on Medicaid financial eligibility criteria and medical/functional determination of necessity to qualify for nursing facility level of care. The initial eligible group shall include those persons eligible for Medicaid now in licensed nursing facilities and those eligible for the Medicaid home and community-based waiver. Eligible persons (and their families in incapacitated cases), in conjunction with the long-term care organization and medical caregivers, shall choose their preferred care setting, to live at home, in other homelike settings, or in a skilled nursing facility. Eligible persons shall be offered choices by the long-term care plan that emphasize the individual's dignity, independence, and quality of life and reflect the principles of person-centered care.

(o) The department shall design a long-term care fee-for-service reimbursement methodology based on resource utilization group methodology principles. The department will conduct an evaluation regarding the adequacy of payments made to providers of care in the long-term care plans to ensure quality of care and compliance with state and federal regulators.

(p) The department shall initiate a review, together with the department of consumer and industry services, other state departments, the long-term care industry, and consumers, of current law and regulations impacting care for the populations to be served by the long-term care plan and will make recommendations to the administration, the legislature, the federal health care financing administration, and congress to change law and regulation to enhance the principles of the long-term care plan. Whenever possible, the contract between the department of community health and long-term care plans should resolve policy and clarify policy contradictions. Contract language will be finalized before implementation.

(q) The department, in consultation with the long-term care industry and consumer representatives, shall have processes in place to resolve implementation issues and make

adjustments, if necessary, in the long-term care plan based on implementation experiences, on a timely basis. An implementation group including the long-term care industry will meet with the department at least bimonthly during implementation.

(r) Joint long-term care plan and department/provider implementation sessions shall be held on a regional basis to explain the long-term care plan contract language with the department and how this impacts the provision of services before enrollment begins.

(s) The plan shall not be implemented in fiscal year 1998-99.

(4) The plan shall include provisions that require participation in the plan by Medicaid beneficiaries be voluntary for the first 5 years of implementation.

Pass-through of substance abuse funds; coordinating agencies.

Sec. 1658. Funds appropriated for substance abuse services through the Medicaid program in the amount of at least $23,328,300.00 shall be contracted in full to coordinating agencies through CMHSPs unless such a pass-through is held to be in violation of federal or state law or rules. If such a pass-through is not permissible, the department shall contract directly with coordinating agencies. CMHSPs shall not assume any contractual or financial liability associated with the pass-through of substance abuse services funds provided to eligible recipients with these funds. The coordinating agencies shall retain financial program responsibilities and liabilities consistent with contract requirements.

Graduate medical education.

Sec. 1659. From the amounts appropriated from section 118 for hospital services, the department shall allocate for graduate medical education no less than was allocated for graduate medical education in fiscal year 1997-98.

Medicaid managed care programs; applicability of certain sections.

Sec. 1660. The following sections are the only ones which 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: 1610, 1611, 1614, 1617, 1624, 1635, 1637, 1638, 1639, 1640, 1641, 1642, 1643, 1654, 1657, and 1658.

Well child visits.

Sec. 1662. (1) The department shall include provisions 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 require reporting from the health plans on their performance in the delivery of services for well child visits and referrals for maternal and infant support services.

(3) 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.

(4) The department shall revise appropriate standards of care used for well child visits based upon recognized national authorities of care, such as the American academy of pediatrics.

Workgroup on EPSDT and maternal and infant support services.

Sec. 1663. The department shall establish a workgroup on EPSDT and maternal and infant support services. The workgroup shall be made up of consumers, advocates, health care providers, and health plan representatives. The workgroup 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 services; use of funds; eligibility criteria; contract; definitions; 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.

Application for MIChild benefit; duties of department.

Sec. 1671. For families applying for a MIChild benefit, the department shall do all of the following:

(a) Provide a single application for determining family eligibility for MIChild, Medicaid, and other health programs offered by the state.

(b) Allow families to submit applications for the program by mail.

(c) Provide immediate and simultaneous determinations of a family's eligibility for MIChild or Medicaid benefits.

(d) Provide MIChild or Medicaid coverage when eligibility is established under subdivision (c).

Expansion of health coverage; federal waiver.

Sec. 1672. (1) The department may seek a waiver from the United States department of health and human services that would allow the state to conduct demonstrations on expanding health coverage to families whose income is at or below 200% of poverty by allowing those families to purchase private health insurance through the use of vouchers or other cost sharing mechanisms.

(2) From the funds appropriated under part 1 for a medical services buy-in program, the department shall provide coverage to adults in MIChild eligible families no longer receiving transitional Medicaid coverage due to employment.

MIChild program; marketing and outreach.

Sec. 1673. (1) From the funds appropriated in part 1, the department shall develop 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.

(2) The department shall fund allowable education and outreach activities for Medicaid eligibility determinations authorized by the personal responsibility and work opportunity reconciliation act of 1996, Public Law 104-193, 110 Stat. 2105.

MIChild program; continuous 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.

Caring program for children; eligibility until establishment in MIChild program.

Sec. 1675. The department shall continue eligibility for all beneficiaries in the caring program for children until their eligibility for the MIChild program is established.

MIChild program; monthly 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.

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

Eligibility changes between Medicaid and MIChild programs; duration of treatment.

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.

Determination of eligibility by department employee.

Sec. 1679. A department employee shall determine eligibility for each MIChild applicant.

MIChild program; implementation in state.

Sec. 1680. Within 120 days after the health care financing administration's approval of the state's MIChild plan, the department shall implement the MIChild program in each county of the state in which a MIChild provider is willing to provide the MIChild benefits at or below the regionally adjusted capitation rate.

Eligibility criteria and verifications.

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 Medicaid healthy kids program eligibility criteria and verifications for determining family group composition shall be used. The following verification shall be used:

(a) For annual income, a W-2 form or most recent pay stub.

(b) For child support, a court order. However, the custodial parent shall supply the department with proof of efforts to obtain that court-ordered support. Verification from the friend of the court will be considered proof of this effort. If the child support is not paid to the parent after this effort, the unpaid child support income shall not be considered for purposes of determining eligibility for MIChild.

(c) For SSI/RSDI income, a yearly statement or bank statements.

(d) For self-employed persons, a completed internal revenue service 1040 form, first page, line 31, showing gross adjusted income.

MIChild program; services provided.

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.

MIChild program as payer of last resort.

Sec. 1683. The MIChild program shall be the payer of last resort for children who have coverage through other state or federal programs or private or commercial health insurance programs.

Patient rights and responsibilities; pamphlet.

Sec. 1686. The department shall prepare and 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; availability of audited version of cost report.

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.

Sec. 1688. In addition to the amounts appropriated in part 1 for long-term care services, there shall be appropriated $10,000,000.00 gross, $5,272,000.00 federal and $4,728,000.00 from the general fund, to the long-term care services line item if House Bill No. 4176 of the 89th Legislature is enacted into law.

This act is ordered to take immediate effect.
Approved September 30, 1998.
Filed with Secretary of State September 30, 1998.

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