May 9, 2013, Introduced by Reps. Lori and Pscholka and referred to the Committee on Michigan Competitiveness.


THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 105. (1) The state department of community health shall establish a program for medical assistance for the medically indigent under title XIX. The director of the state department of community health shall administer the program established by the state department of community health and shall be responsible for determining eligibility under this act. Except as otherwise
provided in this act, the director may delegate the authority to
perform a function necessary or appropriate for the proper
administration of the program.

(2) As used in this section and sections 106 to 112, "peer
review advisory committee" means an entity comprising professionals
and experts who are selected by the director and nominated by an
organization or association or organizations or associations
representing a class of providers.

(3) As used in sections 106 to 112, "professionally accepted
standards" means those standards developed by peer review advisory
committees and professionals and experts with whom the director is
required to consult.

(4) As used in this section and sections 106 to 112,
"provider" means an individual, sole proprietorship, partnership,
association, corporation, institution, agency, or other legal
entity, who has entered into an agreement of enrollment specified
by the director pursuant to section 111b(1)(c).

Sec. 105a. (1) The department shall develop written information that sets forth the eligibility
requirements for participation in the program of medical assistance administered under this act. The written information shall be
updated not less than every 2 years.

(2) The department shall provide copies of the written information described in subsection (1) to all of the
following persons, agencies, and health facilities:

(a) A person applying to the department for participation in the program of medical assistance administered
under this act who is considering institutionalization for the
person or person's family member in a nursing home or home for the
aged.

(b) Each nursing home in the state.
(c) Each hospital in the state.
(d) Each adult foster care facility in the state.
(e) Each area agency on aging.
(f) The office of services to the aging.
(g) Local health departments.
(h) Community mental health boards.
(i) Medicaid and medicare certified home health agencies.
(j) County medical care facilities.
(k) Appropriate department of social services personnel.
(l) Any other person, agency, or health facility determined to
be appropriate by the department.

SEC. 105C. THE DEPARTMENT SHALL PROVIDE A PROCESS BY WHICH
INDIVIDUALS MAY APPLY FOR OR RENEW MEDICAL ASSISTANCE ELIGIBILITY
THROUGH A WEBSITE FROM WHICH THE DEPARTMENT SHALL ENROLL
INDIVIDUALS IN THE APPROPRIATE HEALTH CARE PROGRAM WITHOUT REGARD
TO THE SPECIFIC PROGRAM FOR WHICH THE INDIVIDUAL APPLIES. THIS
SECTION DOES NOT APPLY IF EITHER OF THE FOLLOWING OCCURS:

(A) IF THE DEPARTMENT OF COMMUNITY HEALTH IS UNABLE TO OBTAIN
A WAIVER FROM THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
SERVICES TO IMPLEMENT THE PROVISIONS OF SECTION 105D OR 106(1)(C).
(B) IF AT ANY TIME THE FEDERAL GOVERNMENT DOES NOT PROVIDE
FUNDING AT A LEVEL OF 100% FOR IMPLEMENTATION AND ADMINISTRATION OF
SECTION 106(1)(C).

SEC. 105D. (1) THE DEPARTMENT OF COMMUNITY HEALTH SHALL SEEK A WAIVER FROM THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DO ALL OF THE FOLLOWING:

(A) ENROLL NONDISABLED ADULTS WITH AN ANNUAL INCOME LEVEL BELOW 133% OF THE FEDERAL POVERTY GUIDELINES WHO MEET THE CITIZENSHIP PROVISIONS OF 42 CFR 435.406(A)(1) AND WHO ARE OTHERWISE ELIGIBLE FOR THE MEDICAL ASSISTANCE PROGRAM UNDER THIS ACT INTO A CONTRACTED HEALTH PLAN THAT PROVIDES FOR AN ACCOUNT INTO WHICH MONEY CAN BE DEPOSITED TO PAY FOR INCURRED HEALTH EXPENSES, EXCEPT THAT NONDISABLED ADULTS HAVE THE OPTION TO DECLINE ENROLLMENT INTO THE MEDICAL ASSISTANCE PROGRAM UNDER THIS ACT AND SELECT PRIVATE HEALTH INSURANCE EITHER ON OR OFF THE AMERICAN HEALTH BENEFIT EXCHANGE ESTABLISHED OR OPERATING IN THIS STATE.

(B) GIVE NONDISABLED ADULTS DESCRIBED IN SUBDIVISION (A) A CHOICE IN CHOOSING A CONTRACTED HEALTH PLAN.

(C) ENSURE THAT ALL NONDISABLED ADULTS DESCRIBED IN SUBDIVISION (A) HAVE ACCESS TO A PRIMARY CARE PHYSICIAN AND TO PREVENTIVE SERVICES.

(D) DEVELOP INCENTIVES FOR HEALTHY BEHAVIOR AND FOR PROGRESS MADE TOWARD HEALTHY BEHAVIOR ON THE PART OF NONDISABLED ADULTS DESCRIBED IN SUBDIVISION (A).

(E) DEVELOP INCENTIVES FOR ELIGIBLE ENROLLEES WHO ASSIST THE DEPARTMENT OF COMMUNITY HEALTH IN DETECTING FRAUD AND ABUSE IN THE MEDICAL ASSISTANCE PROGRAM.

(F) ALLOW FOR SERVICES PROVIDED THROUGH TELEMEDICINE.

(G) ALLOW NONDISABLED ADULTS TO RECEIVE MEDICAL ASSISTANCE
UNDER THIS ACT FOR NOT MORE THAN 48 MONTHS. THE 48-MONTH COUNT
BEGIN ON THE DATE THAT THE PROVISIONS OF SECTION 106(1)(C) ARE
IMPLEMENTED AND SHALL NOT INCLUDE ANY MONTHS BEFORE THAT DATE.
NONDISABLED ADULTS WHO HAVE RECEIVED MEDICAL ASSISTANCE UNDER
SECTION 106(1)(C) FOR 48 MONTHS AND ARE NO LONGER ELIGIBLE AS
DESCRIBED IN THIS SUBDIVISION MAY SELECT PRIVATE HEALTH INSURANCE
EITHER ON OR OFF THE AMERICAN HEALTH BENEFIT EXCHANGE ESTABLISHED
OR OPERATING IN THIS STATE.

(2) ANY HOSPITAL THAT PARTICIPATES IN THE MEDICAL ASSISTANCE
PROGRAM UNDER THIS ACT SHALL NOT CHARGE UNINSURED INDIVIDUALS WHO
HAVE AN ANNUAL INCOME LEVEL UNDER 100% OF THE FEDERAL POVERTY
GUIDELINES MORE THAN 115% OF RATES CHARGED TO MEDICARE.

(3) NONDISABLED ADULTS ENROLLED IN THE MEDICAL ASSISTANCE
PROGRAM UNDER SUBSECTION (1)(A) SHALL MAKE CONTRIBUTIONS OF NOT
MORE THAN 5% OF THEIR ANNUAL INCOME INTO THE ACCOUNTS DESCRIBED IN
SUBSECTION (1)(A) BASED ON THE DEPARTMENT OF COMMUNITY HEALTH'S
DETERMINATION OF THE NONDISABLED ADULT'S ABILITY TO PAY.
CONTRIBUTIONS MAY INCLUDE, BUT ARE NOT LIMITED TO, DEDUCTIBLES,
COPAYMENTS, PREMIUMS, OR OTHER APPLICABLE CHARGES AS DETERMINED BY
THE DEPARTMENT OF COMMUNITY HEALTH.

(4) NOT MORE THAN 7 CALENDAR DAYS AFTER RECEIVING A WAIVER
FROM THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
IMPLEMENT THE PROVISIONS OF THIS SECTION, THE DEPARTMENT OF
COMMUNITY HEALTH SHALL SUBMIT A WRITTEN COPY OF THE APPROVED WAIVER
PROVISIONS TO THE LEGISLATURE FOR REVIEW.

(5) BY NOT LATER THAN MARCH 1, 2015 AND ANNUALLY BY EVERY
MARCH 1 AFTER THAT, THE DEPARTMENT OF COMMUNITY HEALTH SHALL
PROVIDE A REPORT TO THE LEGISLATURE THAT INCLUDES, BUT IS NOT LIMITED TO, INFORMATION REGARDING THE IMPACT ON THE HEALTH STATUS OF THE COVERED POPULATION INCLUDING A TARGETED ASSESSMENT RELATED TO EMPLOYABILITY, THE COST EFFECTIVENESS OF THE MEDICAL ASSISTANCE PROGRAM, AND AN EVALUATION OF THE FINANCIAL IMPACT ON THE STATE'S HEALTH CARE AND HEALTH INSURANCE SYSTEMS.

(6) AS USED IN THIS SECTION:

(A) "NONDISABLED ADULT" MEANS AN INDIVIDUAL AGED 21 TO UNDER 65 WHO IS NOT ELIGIBLE THROUGH A DISABILITY CATEGORY EXISTING ON THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION FOR THE PURPOSES OF MEDICAL ASSISTANCE ELIGIBILITY.

(B) "TELEMEDICINE" MEANS THAT TERM AS DEFINED IN SECTION 3476 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3476.

Sec. 106. (1) A medically indigent individual is defined as:

(a) An individual receiving family independence program benefits or an individual receiving supplemental security income under title XVI or state supplementation under title XVI subject to limitations imposed by the director according to title XIX.

(b) Except as provided in section 106a, an individual who meets all of the following conditions:

(i) The individual has applied in the manner the family independence agency prescribes.

(ii) The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or
resources of the patient. The state department is AND THE DEPARTMENT OF COMMUNITY HEALTH ARE subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the state department OR THE DEPARTMENT OF COMMUNITY HEALTH for the care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department OR THE DEPARTMENT OF COMMUNITY HEALTH. A payment may be withheld under this act for medical assistance for an injury or disability for which the individual is entitled to medical care or reimbursement for the cost of medical care under sections 3101 to 3179 of the insurance code of 1956, 1956 PA 218, MCL 500.3101 to 500.3179, or under another policy of insurance providing medical or hospital benefits, or both, for the individual unless the individual's entitlement to that medical care or reimbursement is at issue. If a payment is made, the state department OR THE DEPARTMENT OF COMMUNITY HEALTH, to enforce its subrogation right, may do either of the following: (a) intervene or join in an action or proceeding brought by the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual;
(b) institute and prosecute a legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. The state department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. As provided in section 6023 of the revised judicature act of 1961, 1961 PA 236, MCL 600.6023, the state department or the Department of Community Health, in enforcing its subrogation right, shall not satisfy a judgment against the third person's property that is exempt from levy and sale. The injured, diseased, or disabled individual may proceed in his or her own name, collecting the costs without the necessity of joining the state department, the Department of Community Health, or the state as a named party. The injured, diseased, or disabled individual shall notify the state department or the Department of Community Health of the action or proceeding entered into upon commencement of the action or proceeding. An action taken by the state, or the state department, or the Department of Community Health in connection with the right of recovery afforded by this section does not deny the injured, diseased, or disabled individual any part of the recovery beyond the costs expended on the individual's behalf by the state.
department OR THE DEPARTMENT OF COMMUNITY HEALTH. The costs of legal action initiated by the state shall be paid by the state. A payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the individual is entitled to medical care or the cost of medical care under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, entitlement has not been finally determined, and an arrangement satisfactory to the state department OR THE DEPARTMENT OF COMMUNITY HEALTH has been made for reimbursement if the claim under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, is finally sustained.

(iii) The individual has an annual income that is below, or subject to limitations imposed by the director and because of medical expenses falls below, the protected basic maintenance level. The protected basic maintenance level for 1-person and 2-person families shall be at least 100% of the payment standards generally used to determine eligibility in the family independence program. For families of 3 or more persons, the protected basic maintenance level shall be at least 100% of the payment standard generally used to determine eligibility in the family independence program. These levels shall recognize regional variations and shall not exceed 133-1/3% of the payment standard generally used to determine eligibility in the family independence program.
The individual, if a family independence program related individual and living alone, has liquid or marketable assets of not more than $2,000.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than $3,000.00 in value. The state department of community health shall establish comparable liquid or marketable asset amounts for larger family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead; clothing; household effects; $1,000.00 of cash surrender value of life insurance, except that if the health of the insured makes continuance of the insurance desirable, the entire cash surrender value of life insurance is excluded from consideration, up to the maximum provided or allowed by federal regulations and in accordance with state department of community health rules; the fair market value of tangible personal property used in earning income; an amount paid as judgment or settlement for damages suffered as a result of exposure to agent orange, as defined in section 5701 of the public health code, 1978 PA 368, MCL 333.5701; and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program, the appropriate resource levels and property exemptions specified in title XVI shall be used.

The individual is not an inmate of a public institution except as a patient in a medical institution.

The individual meets the eligibility standards for supplemental security income under title XVI or for state supplementation under the act, subject to limitations imposed by
the director OF THE DEPARTMENT OF COMMUNITY HEALTH according to title XIX; or meets the eligibility standards for family independence program benefits; or meets the eligibility standards for optional eligibility groups under title XIX, subject to limitations imposed by the director OF THE DEPARTMENT OF COMMUNITY HEALTH according to title XIX.

(C) EXCEPT AS OTHERWISE PROVIDED IN SECTION 106A, THE NONDISABLED ADULT HAS AN ANNUAL INCOME LEVEL BELOW 133% OF THE FEDERAL POVERTY GUIDELINES. AS USED IN THIS SUBDIVISION, "NONDISABLED ADULT" MEANS AN INDIVIDUAL 21 YEARS OF AGE TO UNDER 65 YEARS OF AGE WHO IS NOT ELIGIBLE THROUGH A DISABILITY CATEGORY EXISTING ON THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION FOR THE PURPOSES OF MEDICAL ASSISTANCE ELIGIBILITY. THIS SUBDIVISION DOES NOT APPLY IF EITHER OF THE FOLLOWING OCCURS:

(i) IF THE DEPARTMENT OF COMMUNITY HEALTH IS UNABLE TO OBTAIN A WAIVER FROM THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION OR SECTION 105D.

(ii) IF AT ANY TIME THE FEDERAL GOVERNMENT DOES NOT PROVIDE FUNDING AT A LEVEL OF 100% FOR IMPLEMENTATION AND ADMINISTRATION OF THIS SUBDIVISION.

(2) As used in this act:

(a) "Medicaid contracted" "CONTRACTED health plan" means a managed care organization with whom the state department OR THE DEPARTMENT OF COMMUNITY HEALTH contracts to provide or arrange for the delivery of comprehensive health care services as authorized under this act.
(B) "FEDERAL POVERTY GUIDELINES" means the poverty guidelines published annually in the Federal Register by the United States Department of Health and Human Services under its authority to revise the poverty line under section 673(2) of subtitle B of title VI of the Omnibus Budget Reconciliation Act of 1981, 42 USC 9902.

(C) (b) "Medical institution" means a state licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit of a listed institution certified as meeting established standards for a nursing home or hospital in accordance with the laws of this state.

(D) (c) "Title XVI" means title XVI of the social security act, 42 USC 1381 to 1382j and 1383 to 1383f.

(3) An individual receiving medical assistance under this act or his or her legal counsel shall notify the state department of the DEPARTMENT OF COMMUNITY HEALTH when filing an action in which the state department or THE DEPARTMENT OF COMMUNITY HEALTH may have a right to recover expenses paid under this act. If the individual is enrolled in a medicaid-contracted health plan, the individual or his or her legal counsel shall provide notice to the medicaid contracted health plan in addition to providing notice to the state department.

(4) If a legal action in which the state department, THE DEPARTMENT OF COMMUNITY HEALTH, a medicaid-contracted health plan, or both has ALL 3 HAVE a right to recover expenses paid under this act is filed and settled after November 29, 2004 without notice to the state department, THE DEPARTMENT OF COMMUNITY HEALTH, or the medicaid-contracted health plan, the state department, THE
DEPARTMENT OF COMMUNITY HEALTH, or the medicaid contracted health plan may file a legal action against the individual or his or her legal counsel, or both, to recover expenses paid under this act. The attorney general shall recover any cost or attorney fees associated with a recovery under this subsection.

(5) The state department OR THE DEPARTMENT OF COMMUNITY HEALTH has first priority against the proceeds of the net recovery from the settlement or judgment in an action settled in which notice has been provided under subsection (3). A medicaid contracted health plan has priority immediately after the state department OR THE DEPARTMENT OF COMMUNITY HEALTH in an action settled in which notice has been provided under subsection (3). The state department, THE DEPARTMENT OF COMMUNITY HEALTH, and a medicaid contracted health plan shall recover the full cost of expenses paid under this act unless the state department, THE DEPARTMENT OF COMMUNITY HEALTH, or the medicaid contracted health plan agrees to accept an amount less than the full amount. If the individual would recover less against the proceeds of the net recovery than the expenses paid under this act, the state department, THE DEPARTMENT OF COMMUNITY HEALTH, or medicaid contracted health plan, and the individual shall share equally in the proceeds of the net recovery. As used in this subsection, "net recovery" means the total settlement or judgment less the costs and fees incurred by or on behalf of the individual who obtains the settlement or judgment.

Sec. 107. (1) In establishing financial eligibility for the medically indigent, as defined in section 106, income shall be disregarded in accordance with standards established for the
related categorical assistance program. For medical assistance only, income shall include the amount of contribution that an estranged spouse or parent for a minor child is making to the applicant according to the standards of the state department of community health, or according to a court determination, if there is a court determination. Nothing in this section eliminates the responsibility of support established in section 76 for cash assistance received under this act.

(2) the department of community health shall apply a modified adjusted gross income methodology in determining if an individual's annual income level is below 133% of the federal poverty guidelines. This subsection does not apply if either of the following occurs:

(A) if the department of community health is unable to obtain a waiver from the united states department of health and human services to implement the provisions of section 105d or 106(1)(c).

(B) if at any time the federal government does not provide funding at a level of 100% for implementation and administration of section 106(1)(c).

Sec. 108. A medically indigent person as defined under subdivision (1) of section 106, 106(1) is entitled to all the services enumerated in subsections (a), (b), (c), (d), (e) and (f) of section 109. A medically indigent person as defined under subdivision (2) of section 106 106(2) is entitled to medical services enumerated in subsections (a), (c) and (e) of section 109. He shall also be or she is entitled to the services enumerated in subsections (b), section 109(b), (d),
and (f) of section 109 to the extent of appropriations made available by the legislature for the fiscal year. Medical services shall be rendered upon certification by the attending licensed physician and dental services shall be rendered upon certification of the attending licensed dentist that a service is required for the treatment of an individual. The services of a medical institution shall be rendered only after referral by a licensed physician or dentist and certification by him OR HER that the services of the medical institution are required for the medical or dental treatment of the individual, except that referral is not necessary in case of an emergency. Periodic recertification that medical treatment which extends over a period of time is required in accordance with regulations of the state department shall be a condition of continuing eligibility to receive medical assistance. To comply with federal statutes governing medicaid, the state department OF COMMUNITY HEALTH shall provide such early and periodic screening, diagnostic and treatment services to eligible children as it deems necessary.

Sec. 109c. (1) The state department OF COMMUNITY HEALTH shall include, as part of its program of medical services under this act, home- or community-based services to eligible persons whom the state department OF COMMUNITY HEALTH determines would otherwise require nursing home services or similar institutional care services under section 109. The home- or community-based services shall be offered to qualified eligible persons who are receiving inpatient hospital or nursing home services as an alternative to
those forms of care.

(2) The home- or community-based services shall include safeguards adequate to protect the health and welfare of participating eligible persons, and shall be provided according to a written plan of care for each person. The services available under the home- or community-based services program shall include, at a minimum, all of the following:

(a) Home delivered meals.
(b) Chore services.
(c) Homemaker services.
(d) Respite care.
(e) Personal care.
(f) Adult day care.
(g) Private duty nursing.
(h) Mental health counseling.
(i) Caregiver training.
(j) Emergency response systems.
(k) Home modification.
(l) Transportation.
(m) Medical equipment and supply services.

(3) This section shall be implemented so that the average per capita expenditure for home- or community-based services for eligible persons receiving those services does not exceed the estimated average per capita expenditure that would have been made for those persons had they been receiving nursing home services, inpatient hospital or similar institutional care services instead.

(4) The state department of Community Health shall seek a
waiver necessary to implement this program from the federal
department of health and human services, as provided in section
1915 of title XIX, 42 U.S.C.—USC 1396n. The department OF COMMUNITY
HEALTH shall request any modifications of the waiver that are
necessary in order to expand the program in accordance with
subsection (9).

(5) The state department OF COMMUNITY HEALTH shall establish
policy for identifying the rules for persons receiving inpatient
hospital or nursing home services who may qualify for home- or
community-based services. The rules shall contain, at a minimum, a
listing of diagnoses and patient conditions to which the option of
home- or community-based services may apply, and a procedure to
determine if the person qualifies for home- or community-based
services.

(6) The state department OF COMMUNITY HEALTH shall provide to
the legislature and the governor an annual report showing the
detail of its home- and community-based case finding and placement
activities. At a minimum, the report shall contain each of the
following:

(a) The number of persons provided home- or community-based
services who would otherwise require inpatient hospital services. This shall include a description of medical conditions, services
provided, and projected cost savings for these persons.

(b) The number of persons provided home- or community-based
services who would otherwise require nursing home services. This
shall include a description of medical conditions, services
provided, and projected cost savings for these persons.
(c) The number of persons and the annual expenditure for personal care services.

(d) The number of hearings requested concerning home- or community-based services and the outcome of each hearing which has been adjudicated during the year.

(7) The written plan of care required under subsection (2) for an eligible person shall not be changed unless the change is prospective only, and the state department of community health does both of the following:

(a) Not later than 30 days before making the change, except in the case of emergency, consults with the eligible person or, in the case of a child, with the child's parent or guardian.

(b) Consults with each medical service provider involved in the change. This consultation shall be documented in writing.

(8) An eligible person who is receiving home- or community-based services under this section, and who is dissatisfied with a change in his or her plan of care or a denial of any home- or community-based service, may demand a hearing as provided in section 9, and subsequently may appeal the hearing decision to circuit court as provided in section 37.

(9) The state department of community health shall expand the home- and community-based services program by increasing the number of counties in which it is available, in conformance with this subsection. The program may be limited in total cost and in the number of recipients per county who may receive services at 1 time. Subject to obtaining the waiver and any modifications of the waiver sought under subsection (4), the program shall be expanded as
follows:

(a) Not later than 1 year after the effective date of this
subsection, JULY 14, 1995, home- and community-based services shall
be available to eligible applicants in those counties that, when
combined, contain at least 1/4 of the population of this state.

(b) Not later than 2 years after the effective date of this
subsection, JULY 14, 1996, home- and community-based services shall
be available to eligible applicants in those counties that, when
combined, contain at least 1/2 of the population of this state.

(c) Not later than 3 years after the effective date of this
subsection, JULY 14, 1997, home- and community-based services shall
be available to eligible applicants in those counties that, when
combined, contain at least 3/4 of the population of this state.

(d) Not later than 4 years after the effective date of this
subsection, JULY 14, 1998, home- and community-based services shall
be available to eligible applicants on a statewide basis.

(10) The state department of community health shall work with
the office of services to the aging in implementing the home- and
community-based services program, including the provision of
preadmission screening, case management, and recipient access to
services.