SUBSTITUTE FOR

SENATE BILL NO. 172

A bill to make appropriations for the department of community health and certain state purposes related to mental health, public health, and medical services for the fiscal year ending September 30, 2012; to provide for the expenditure of those appropriations; to provide anticipated appropriations for the fiscal year ending September 30, 2013; to create funds; to require and 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

FOR FISCAL YEAR 2011-2012

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, 2012, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH

APPROPRIATION SUMMARY

Full-time equated unclassified positions..... 6.0	
Full-time equated classified positions..... 4,029.5	
Average population 893.0	
GROSS APPROPRIATION.....	$ 13,833,859,600
Interdepartmental grant revenues:	
Total interdepartmental grants and intradepartmental transfers	4,528,700
ADJUSTED GROSS APPROPRIATION.....	$ 13,829,330,900
Federal revenues:	
Total other federal revenues.....	8,686,999,400
Special revenue funds:	
Total local revenues.....	248,426,200
Total private revenues.....	96,494,700
Merit award trust fund.....	86,744,500
Total other state restricted revenues.....	2,069,581,200
State general fund/general purpose.....	$ 2,641,084,900

Sec. 102. DEPARTMENTWIDE ADMINISTRATION

Full-time equated unclassified positions..... 6.0	
Full-time equated classified positions..... 175.2	
Director and other unclassified--6.0 FTE positions ...	$ 583,900
Departmental administration and management--165.2	

FTE positions			16,667,000
Worker's compensation program			8,772,300
Rent and building occupancy			10,628,100
Developmental disabilities council and projects--10.0 FTE positions			2,855,700
GROSS APPROPRIATION		$	39,507,000
Appropriated from:			
Federal revenues:			
Total other federal revenues			14,092,400
Special revenue funds:			
Total private revenues			35,100
Total other state restricted revenues			2,502,900
State general fund/general purpose		$	22,876,600

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

Full-time equated classified positions	111.5		
Mental health/substance abuse program administration--110.5 FTE positions		$	17,386,800
Gambling addiction--1.0 FTE position			3,000,000
Protection and advocacy services support			194,400
Community residential and support services			1,777,200
Federal and other special projects			2,697,200
Family support subsidy			19,470,500
Housing and support services			9,306,800
GROSS APPROPRIATION		$	53,832,900
Appropriated from:			
Federal revenues:			

Total federal revenues		37,301,600
Special revenue funds:		
Total private revenues		190,000
Total other state restricted revenues		3,000,000
State general fund/general purpose	$	13,341,300

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

Full-time equated classified positions 9.5		
Medicaid mental health services	$	2,055,796,700
Community mental health non-Medicaid services		268,839,200
Medicaid adult benefits waiver		32,056,100
Mental health services for special populations		6,873,800
Medicaid substance abuse services		42,410,600
CMHSP, purchase of state services contracts		134,201,900
Civil service charges		1,499,300
Federal mental health block grant--2.5 FTE positions		15,397,500
Community substance abuse prevention, education, and treatment programs		81,737,500
Children's waiver home care program		18,944,800
Nursing home PAS/ARR-OBRA--7.0 FTE positions		12,179,300
Children with serious emotional disturbance waiver		8,188,000
GROSS APPROPRIATION	$	2,678,124,700
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of human services		2,769,000
Federal revenues:		

Total other federal revenues		1,519,433,700
Special revenue funds:		
Total local revenues		25,228,900
Total other state restricted revenues		22,314,900
State general fund/general purpose	$	1,108,378,200

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

Total average population 893.0		
Full-time equated classified positions 2,194.2		
Caro regional mental health center - psychiatric hospital - adult--468.3 FTE positions	$	56,772,200
Average population 185.0		
Kalamazoo psychiatric hospital - adult--483.1 FTE positions		54,782,400
Average population 189.0		
Walter P. Reuther psychiatric hospital - adult--433.3 FTE positions		52,297,800
Average population 234.0		
Hawthorn center - psychiatric hospital - children and adolescents--230.9 FTE positions		27,075,900
Average population 75.0		
Center for forensic psychiatry--578.6 FTE positions		66,767,900
Average population 210.0		
Revenue recapture		750,000
IDEA, federal special education		120,000
Special maintenance		332,500

Purchase of medical services for residents of hospitals and centers		445,600
Gifts and bequests for patient living and treatment environment		1,000,000
GROSS APPROPRIATION	$	260,344,300
Appropriated from:		
Interdepartmental grant revenues:		
Federal revenues:		
Total other federal revenues		29,921,200
Special revenue funds:		
CMHSP, purchase of state services contracts		134,201,900
Other local revenues		17,494,500
Total private revenues		1,000,000
Total other state restricted revenues		15,948,400
State general fund/general purpose	$	61,778,300
Sec. 106. PUBLIC HEALTH ADMINISTRATION		
Full-time equated classified positions 91.7		
Public health administration--7.3 FTE positions	$	1,557,200
Minority health grants and contracts--3.0 FTE positions		612,700
Promotion of healthy behaviors		975,900
Vital records and health statistics--81.4 FTE positions		9,442,800
GROSS APPROPRIATION	$	12,588,600
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of human		

services		1,171,500
Federal revenues:		
Total other federal revenues		4,887,900
Special revenue funds:		
Total private revenues		300,000
Total other state restricted revenues		4,974,700
State general fund/general purpose	$	1,254,500

Sec. 107. HEALTH POLICY, REGULATION, AND PROFESSIONS

Full-time equated classified positions 462.1		
Health systems administration--199.6 FTE positions	$	22,369,300
Emergency medical services program state staff--23.0 FTE positions		4,850,300
Radiological health administration--21.4 FTE positions		3,179,700
Emergency medical services grants and services		660,000
Health professions--163.0 FTE positions		26,945,900
Background check program--5.5 FTE positions		2,720,500
Health policy and regulation administration--30.2 FTE positions		3,756,600
Nurse scholarship, education, and research program--3.0 FTE positions		1,744,200
Certificate of need program administration--14.0 FTE positions		2,071,100
Rural health services--1.0 FTE position		1,410,300
Michigan essential health provider		872,700
Primary care services--1.4 FTE positions		3,086,600
GROSS APPROPRIATION	$	73,667,200

Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of treasury, Michigan state hospital finance authority.		116,300
Federal revenues:		
Total other federal revenues.....		25,410,200
Special revenue funds:		
Total local revenues.....		100,000
Total private revenues.....		455,000
Total other state restricted revenues.....		41,793,400
State general fund/general purpose.....	$	5,792,300
Sec. 108. INFECTIOUS DISEASE CONTROL		
Full-time equated classified positions..... 50.7		
AIDS prevention, testing, and care programs--12.7 FTE positions	$	59,449,300
Immunization local agreements.....		11,975,200
Immunization program management and field support--15.0 FTE positions		1,786,300
Pediatric AIDS prevention and control--1.0 FTE position		1,231,400
Sexually transmitted disease control local agreements		3,360,700
Sexually transmitted disease control management and field support--22.0 FTE positions.....		3,743,300
GROSS APPROPRIATION.....	$	81,546,200
Appropriated from:		
Federal revenues:		
Total other federal revenues.....		43,490,200

	Special revenue funds:		
	Total private revenues		27,707,700
	Total other state restricted revenues		7,470,600
	State general fund/general purpose	$	2,877,700
	Sec. 109. LABORATORY SERVICES		
	Full-time equated classified positions 111.0		
	Laboratory services--111.0 FTE positions	$	17,183,900
	GROSS APPROPRIATION	$	17,183,900
	Appropriated from:		
	Interdepartmental grant revenues:		
	Interdepartmental grant from the department of environmental quality		471,900
	Federal revenues:		
	Total federal revenues		2,092,300
	Special revenue funds:		
	Total other state restricted revenues		8,267,600
	State general fund/general purpose	$	6,352,100
	Sec. 110. EPIDEMIOLOGY		
	Full-time equated classified positions 126.7		
	AIDS surveillance and prevention program		2,254,100
	Asthma prevention and control--2.6 FTE positions		856,900
	Bioterrorism preparedness--66.6 FTE positions		49,286,900
	Epidemiology administration--40.0 FTE positions		8,202,000
	Lead abatement program--7.0 FTE positions		2,647,700
	Newborn screening follow-up and treatment services--10.5 FTE positions		5,337,800
	Tuberculosis control and prevention		867,000

GROSS APPROPRIATION.....	$	69,452,400
Appropriated from:		
Federal revenues:		
Total federal revenues.....		61,271,300
Special revenue funds:		
Total private revenues.....		25,000
Total other state restricted revenues.....		6,367,900
State general fund/general purpose.....	$	1,788,200

Sec. 111. LOCAL HEALTH ADMINISTRATION AND GRANTS

Full-time equated classified positions..... 2.0		
Essential local public health services.....	$	37,386,100
Implementation of 1993 PA 133, MCL 333.17015.....		20,000
Local health services--2.0 FTE positions.....		500,000
Medicaid outreach cost reimbursement to local health departments		9,000,000
GROSS APPROPRIATION.....	$	46,906,100
Appropriated from:		
Federal revenues:		
Total federal revenues.....		9,500,000
Special revenue funds:		
Total local revenues.....		5,150,000
State general fund/general purpose.....	$	32,256,100

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

Full-time equated classified positions..... 75.5		
Cancer prevention and control program--12.0 FTE positions	$	14,298,200

Chronic disease control and health promotion		
administration--33.4 FTE positions		5,950,100
Diabetes and kidney program--12.2 FTE positions		1,777,600
Injury control intervention project		170,000
Public health traffic safety coordination--1.0 FTE		
position		87,500
Smoking prevention program--14.0 FTE positions		2,075,000
Violence prevention--2.9 FTE positions		2,123,200
GROSS APPROPRIATION	$	26,481,600
Appropriated from:		
Federal revenues:		
Total federal revenues		23,969,200
Special revenue funds:		
Total private revenues		61,600
Total other state restricted revenues		649,700
State general fund/general purpose	$	1,801,100

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

Full-time equated classified positions..... 55.1

Childhood lead program--6.0 FTE positions	$	1,598,400
Dental programs--3.0 FTE positions		992,000
Dental program for persons with developmental		
disabilities		151,000
Family, maternal, and children's health services		
administration--43.6 FTE positions		6,047,700
Family planning local agreements		9,085,700
Local MCH services		7,018,100

Pregnancy prevention program			602,100
Prenatal care outreach and service delivery support			42,500
Special projects--2.5 FTE positions			8,546,500
Sudden infant death syndrome program			321,300
GROSS APPROPRIATION		$	34,405,300
Appropriated from:			
Federal revenues:			
Total federal revenues			30,552,600
Special revenue funds:			
Total local revenues			75,000
State general fund/general purpose		$	3,777,700

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

Full-time equated classified positions	45.0		
Women, infants, and children program administration and special projects--45.0 FTE positions		$	13,825,200
Women, infants, and children program local agreements and food costs			254,200,800
GROSS APPROPRIATION		$	268,026,000
Appropriated from:			
Federal revenues:			
Total federal revenues			209,412,200
Special revenue funds:			
Total private revenues			58,613,800
State general fund/general purpose		$	0

Sec. 115. CHILDREN'S SPECIAL HEALTH CARE SERVICES

Full-time equated classified positions	47.8		

Children's special health care services		
administration--45.0 FTE positions	$	5,245,700
Bequests for care and services--2.8 FTE positions		1,511,400
Outreach and advocacy		3,773,500
Nonemergency medical transportation		2,679,300
Medical care and treatment		278,471,300
GROSS APPROPRIATION	$	291,681,200
Appropriated from:		
Federal revenues:		
Total other federal revenues		166,222,000
Special revenue funds:		
Total private revenues		996,800
Total other state restricted revenues		3,843,600
State general fund/general purpose	$	120,618,800

Sec. 116. CRIME VICTIM SERVICES COMMISSION

Full-time equated classified positions..... 13.0

Grants administration services--13.0 FTE positions	$	1,811,300
Justice assistance grants		19,106,100
Crime victim rights services grants		16,570,000
GROSS APPROPRIATION	$	37,487,400
Appropriated from:		
Federal revenues:		
Total federal revenues		23,467,200
Special revenue funds:		
Total other state restricted revenues		14,020,200
State general fund/general purpose	$	0

Sec. 117. OFFICE OF SERVICES TO THE AGING

Full-time equated classified positions..... 43.5		
Office of services to aging administration--43.5 FTE positions	$	6,408,800
Community services.....		34,289,000
Nutrition services.....		35,430,200
Foster grandparent volunteer program.....		1,898,600
Retired and senior volunteer program.....		533,300
Senior companion volunteer program.....		1,363,700
Employment assistance.....		3,792,500
Respite care program.....		5,868,700
GROSS APPROPRIATION.....	$	89,584,800
Appropriated from:		
Federal revenues:		
Total federal revenues.....		57,159,200
Special revenue funds:		
Total private revenues.....		677,500
Merit award trust fund.....		4,468,700
Total other state restricted revenues.....		1,400,000
State general fund/general purpose.....	$	25,879,400

Sec. 118. MEDICAL SERVICES ADMINISTRATION

Full-time equated classified positions..... 415.0		
Medical services administration--415.0 FTE positions .	$	65,057,000
Facility inspection contract.....		132,800
MIChild administration.....		4,327,800
GROSS APPROPRIATION.....	$	69,517,600
Appropriated from:		
Federal revenues:		

Total other federal revenues		47,476,900
Special revenue funds:		
Total local revenues		105,900
Total private revenues		100,000
Total other state restricted revenues		110,100
State general fund/general purpose	$	21,724,700

Sec. 119. MEDICAL SERVICES

Hospital services and therapy	$	1,138,897,800
Hospital disproportionate share payments		45,000,100
Physician services		290,369,500
Medicare premium payments		409,169,400
Pharmaceutical services		318,717,600
Home health services		6,791,100
Hospice services		144,637,700
Transportation		15,009,800
Auxiliary medical services		6,252,200
Dental services		158,500,800
Ambulance services		9,271,600
Long-term care services		1,717,837,500
Medicaid home- and community-based services waiver		205,940,500
Adult home help services		289,032,900
Personal care services		14,421,500
Program of all-inclusive care for the elderly		30,707,800
Health plan services		3,936,122,200
MIChild program		51,753,100
Plan first family planning waiver		13,089,200
Medicaid adult benefits waiver		105,877,700

Special indigent care payments		88,518,500
Federal Medicare pharmaceutical program		185,599,300
Maternal and child health		20,279,500
Subtotal basic medical services program		9,201,797,300
School-based services		91,296,500
Special Medicaid reimbursement		329,823,200
Subtotal special medical services payments		421,119,700
GROSS APPROPRIATION	$	9,622,917,000
Appropriated from:		
Federal revenues:		
Total other federal revenues		6,337,148,100
Special revenue funds:		
Total local revenues		66,070,000
Total private revenues		6,332,200
Merit award trust fund		82,275,800
Total other state restricted revenues		1,933,691,000
State general fund/general purpose	$	1,197,399,900

Sec. 120. INFORMATION TECHNOLOGY

Information technology services and projects	$	34,881,700
Michigan Medicaid information system		25,723,700
GROSS APPROPRIATION	$	60,605,400
Appropriated from:		
Federal revenues:		
Total federal revenues		44,191,200
Special revenue funds:		
Total other state restricted revenues		3,226,200
State general fund/general purpose	$	13,188,000

PART 2

PROVISIONS CONCERNING APPROPRIATIONS

FOR FISCAL YEAR 2011-2012

GENERAL SECTIONS

Sec. 201. Pursuant to section 30 of article IX of the state constitution of 1963, total state spending from state resources under part 1 for fiscal year 2011-2012 is $4,797,410,600.00 and state spending from state resources to be paid to local units of government for fiscal year 2011-2012 is $1,333,598,700.00. The itemized statement below identifies appropriations from which spending to local units of government will occur:

DEPARTMENT OF COMMUNITY HEALTH		
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS		
Community residential and support services	$	170,100
Housing and support services		599,800
COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS		
Community substance abuse prevention, education, and treatment programs	$	12,792,500
Medicaid mental health services		650,333,100
Community mental health non-Medicaid services		268,839,200
Medicaid adult benefits waiver		10,854,200
Mental health services for special populations		6,873,800
Medicaid substance abuse services		14,360,200
Children's waiver home care program		5,906,800

Nursing home PASARR		2,717,200
HEALTH POLICY, REGULATION, AND PROFESSIONS		
Primary care services	$	88,900
INFECTIOUS DISEASE CONTROL		
AIDS prevention, testing, and care programs	$	1,000,000
Sexually transmitted disease control local agreements		226,200
LABORATORY SERVICES		
Laboratory services	$	13,700
LOCAL HEALTH ADMINISTRATION AND GRANTS		
Implementation of 1993 PA 133, MCL 333.17015	$	8,000
Essential local public health services		32,236,100
CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION		
Cancer prevention and control program	$	450,000
Chronic disease control and health promotion administration		261,600
Diabetes and kidney program		54,500
Smoking prevention program		800,000
FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES		
Childhood lead program	$	51,100
Pregnancy prevention program		90,000
CHILDREN'S SPECIAL HEALTH CARE SERVICES		
Medical care and treatment	$	895,700
Outreach and advocacy		1,237,500
MEDICAL SERVICES		
Dental services	$	2,005,600
Long-term care services		269,214,200
Transportation		2,572,700

Medicaid adult benefits waiver		6,186,600
Hospital services and therapy		5,316,800
Physician services		4,251,500
OFFICE OF SERVICES TO THE AGING		
Community services	$	11,310,000
Nutrition services		8,787,000
Foster grandparent volunteer program		577,800
Retired and senior volunteer program		148,800
Senior companion volunteer program		182,700
Respite care program		5,384,800
CRIME VICTIM SERVICES COMMISSION		
Crime victim rights services grants	$	6,800,000
TOTAL OF PAYMENTS TO LOCAL UNITS OF GOVERNMENT	$	1,333,598,700

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

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

Sec. 203. As used in this act:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "ARRA" means the American recovery and reinvestment act of 2009, Public Law 111-5.

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

(d) "Current fiscal year" means the fiscal year ending

September 30, 2012.

(e) "Department" means the department of community health.

(f) "Director" means the director of the department.

(g) "DSH" means disproportionate share hospital.

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

(i) "Federal health care reform legislation" means the patient protection and affordable care act, Public Law 111-148, and the health care and education reconciliation act of 2010, Public Law 111-152.

(j) "Federal poverty level" 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 42 USC 9902.

(k) "FMAP" means federal medical assistance percentages.

(*l*) "FTE" means full-time equated.

(m) "GME" means graduate medical education.

(n) "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.

(o) "HEDIS" means healthcare effectiveness data and information set.

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

(q) "HMO" means health maintenance organization.

(r) "IDEA" means the individuals with disabilities education act, 20 USC 1400 to 1482.

(s) "IDG" means interdepartmental grant.

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

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

(v) "MIHP" means the maternal infant health program.

(w) "PASARR" means the preadmission screening and annual resident review required under the omnibus budget reconciliation act of 1987, section 1919(e)(7) of the social security act, and 42 USC 1396r.

(x) "PIHP" means a specialty prepaid inpatient health plan for Medicaid mental health services, services to individuals with developmental disabilities, and substance abuse services as described in section 232b of the mental health code, 1974 PA 258, MCL 330.1232b.

(y) "Title XVIII" and "Medicare" mean title XVIII of the social security act, 42 USC 1395 to 1395iii.

(z) "Title XIX" and "Medicaid" mean title XIX of the social security act, 42 USC 1396 to 1396w-2.

(aa) "Title XX" means title XX of the social security act, 42 USC 1397 to 1397f.

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

Sec. 205. (1) A hiring freeze is imposed on the state classified civil service. State departments and agencies are prohibited from hiring any new full-time state classified civil service employees and prohibited from filling any vacant state classified civil service positions. This hiring freeze does not apply to internal transfers of classified employees from 1 position

to another within a department.

(2) The state budget director may grant exceptions to this hiring freeze when the state budget director believes that the hiring freeze will render a state department or agency unable to deliver basic services, will cause loss of revenue to the state, will result in the inability of the state to receive federal funds, or will necessitate additional expenditures that exceed any savings from maintaining a vacancy. The state budget director shall report annually to the chairpersons of the senate and house standing committees on appropriations the number of exceptions to the hiring freeze approved during the previous quarter and the reasons to justify the exception.

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

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

(3) In addition to the funds appropriated in part 1, there is appropriated an amount not to exceed $20,000,000.00 for local contingency funds. These funds are not available for expenditure

until they have been transferred to another line item in this act under section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

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

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

Sec. 209. Funds appropriated in part 1 shall not be used for the purchase of foreign goods or services, or both, if competitively priced and of comparable quality American goods or services, or both, are available. Preference shall be given to goods or services, or both, manufactured or provided by Michigan businesses if they are competitively priced and of comparable quality. In addition, preference shall be given to goods or services, or both, that are manufactured or provided by Michigan businesses owned and operated by veterans if they are competitively priced and of comparable quality.

Sec. 210. The director shall take all reasonable steps to ensure businesses in deprived and depressed communities compete for and perform contracts to provide services or supplies, or both. The

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

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

(2) The department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the balance of each of the restricted funds administered by the department as of September 30 of the current fiscal year.

Sec. 212. (1) On or before February 1 of the current fiscal year, 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.

(2) Upon the release of the next fiscal year executive budget recommendation, the department shall report to the same parties in subsection (1) 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 next fiscal year executive budget proposal.

Sec. 214. The use of state restricted tobacco tax revenue received for the purpose of tobacco prevention, education, and reduction efforts and deposited in the healthy Michigan fund shall not be used for lobbying as defined in section 5 of 1978 PA 472, MCL 4.415, and shall not be used in attempting to influence the decisions of the legislature, the governor, or any state agency.

Sec. 215. (1) The department shall report to the house and senate appropriations subcommittees on the budget for the department, the joint committee on administrative rules, and the senate and house fiscal agencies by no later than April 1 of the current fiscal year on each specific policy change made by the department to implement a public act affecting that department that took effect during the preceding calendar year.

(2) Funds appropriated in part 1 shall not be used by the department to adopt a rule that will apply to a small business and that will have a disproportionate economic impact on small businesses because of the size of those businesses if the department fails to reduce the disproportionate economic impact of the rule on small businesses as provided under section 40 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.240.

(3) As used in this section:

(a) "Rule" means that term as defined under section 7 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.207.

(b) "Small business" means that term as defined under section 7a of the administrative procedures act of 1969, 1969 PA 306, MCL 24.207a.

Sec. 216. (1) In addition to funds appropriated in part 1 for

all programs and services, there is appropriated for write-offs of accounts receivable, deferrals, and for prior year obligations in excess of applicable prior year appropriations, an amount equal to total write-offs and prior year obligations, but not to exceed amounts available in prior year revenues.

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

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

Sec. 218. The department shall include the following in its annual list of proposed basic health services as required in part 23 of the public health code, 1978 PA 368, MCL 333.2301 to 333.2321:

(a) Immunizations.

(b) Communicable disease control.

(c) Sexually transmitted disease control.

(d) Tuberculosis control.

(e) Prevention of gonorrhea eye infection in newborns.

(f) Screening newborns for the conditions listed in section 5431 of the public health code, 1978 PA 368, MCL 333.5431, or recommended by the newborn screening quality assurance advisory

committee created under section 5430 of the public health code, 1978 PA 368, MCL 333.5430.

(g) Community health annex of the Michigan emergency management plan.

(h) Prenatal care.

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

(a) A detailed description of each funded project.

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

(c) The expected project duration.

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

(2) On or before September 30 of the current fiscal year, the department shall provide to the same parties listed in subsection (1) a copy of all reports, studies, and publications produced by the Michigan public health institute, its subcontractors, or the

department with the funds appropriated in part 1 and allocated to the Michigan public health institute.

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

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

Sec. 264. (1) Upon submission of a Medicaid waiver, a Medicaid state plan amendment, or a similar proposal to the centers for Medicare and Medicaid services, the department shall notify the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies of the submission.

(2) The department shall provide written or verbal biannual reports to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies summarizing the status of any new or ongoing discussions with the centers for Medicare and Medicaid services or the federal department of health and human services regarding potential or future Medicaid waiver applications.

Sec. 265. The departments and agencies receiving

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

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

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

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

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

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

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

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

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

appropriations, the senate and house fiscal agencies, and the state budget director. The report shall include the following information:

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

(b) The destination of each travel occurrence.

(c) The dates of each travel occurrence.

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

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

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

Sec. 267. A department or state agency shall not take disciplinary action against an employee for communicating with a member of the legislature or his or her staff.

Sec. 270. Within 180 days after receipt of the notification from the attorney general's office of a legal action in which expenses had been recovered pursuant to section 106(4) of the social welfare act, 1939 PA 280, MCL 400.106, or any other statute under which the department has the right to recover expenses, the department shall submit a written report to the house and senate appropriations subcommittees on community health, the house and

senate fiscal agencies, and the state budget office which includes, at a minimum, all of the following:

(a) The total amount recovered from the legal action.

(b) The program or service for which the money was originally expended.

(c) Details on the disposition of the funds recovered such as the appropriation or revenue account in which the money was deposited.

(d) A description of the facts involved in the legal action.

Sec. 276. Funds appropriated in part 1 shall not be used by a principal executive department, state agency, or authority to hire a person to provide legal services that are the responsibility of the attorney general. This prohibition does not apply to legal services for bonding activities and for those activities that the attorney general authorizes.

Sec. 282. (1) The department, through its organizational units responsible for departmental administration, operation, and finance, shall establish uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by the following entities:

(a) Coordinating agencies on substance abuse and the Salvation Army harbor light program that receive payment or reimbursement from funds appropriated under section 104.

(b) Area agencies on aging and local providers that receive payment or reimbursement from funds appropriated under section 117.

(2) By May 15 of the current fiscal year, the department shall

provide a written draft of its proposed definitions, standards, and instructions to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

Sec. 287. Not later than December 1, 2011, the department shall prepare and transmit a report that provides for estimates of the total general fund/general purpose appropriation lapses at the close of the previous fiscal year. This report shall summarize the projected year-end general fund/general purpose appropriation lapses by major departmental program or program areas. The report shall be transmitted to the office of the state budget, the chairpersons of the senate and house appropriations committees, and the fiscal agencies.

Sec. 292. (1) On a quarterly basis, the department shall report on the number of full-time equated positions in pay status by civil service classification to the senate and house of representatives standing committees on appropriations subcommittees on community health and the senate and house fiscal agencies.

(2) From the funds appropriated in part 1, the department shall develop, post, and maintain on a user-friendly and publicly accessible Internet website all expenditures made by the department within a fiscal year. The posting must include the purpose for which each expenditure is made. Funds appropriated in part 1 from the ARRA shall also be included on a publicly accessible website maintained by the Michigan economic recovery office. The department shall not provide financial information on its website under this section if doing so would violate a federal or state law, rule,

regulation, or guideline that establishes privacy or security standards applicable to that section.

Sec. 294. (1) It is the intent of the legislature that, in fiscal year 2012-2013, funding appropriated in fiscal year 2011-2012 for all of the following line items and programs shall be allocated on a competitive basis:

(a) The mental health services for special populations line item.

(b) The multicultural grants and clinic grants funded from the primary care services line item.

(c) The GF/GP grants funded from the special projects line item.

(d) The injury control intervention line item.

(e) School health centers funded from the health plan services line item.

(2) Each program identified in subsection (1) shall only be eligible for the funding described in subsection (1) if it provides information to the department on program allocations, goals, and outcomes by July 1 of the current fiscal year.

Sec. 295. It is the intent of the legislature that funds appropriated in this act shall not be spent on efforts to implement the federal health care reform legislation.

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Sec. 401. Funds appropriated in part 1 are intended to support a system of comprehensive community mental health services under the full authority and responsibility of local CMHSPs or PIHPs. The

department shall ensure that each CMHSP or PIHP provides all of the following:

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

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

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

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

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

(f) A system of continuous quality improvement.

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

(h) A system that serves at-risk and delinquent youth as

required under the provisions of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

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

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

(a) Any new contracts with CMHSPs or PIHPs that would affect rates or expenditures are enacted.

(b) Any amendments to contracts with CMHSPs or PIHPs that would affect rates or expenditures are enacted.

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

Sec. 403. (1) From the funds appropriated in part 1 for mental

health services for special populations, the department shall ensure that CMHSPs or PIHPs meet with multicultural service providers to develop a workable framework for contracting, service delivery, and reimbursement.

(2) Funds appropriated in part 1 for mental health services for special populations shall not be utilized for services provided to illegal immigrants, fugitive felons, and individuals who are not residents of this state. The department shall maintain contracts with recipients of multicultural services grants that mandate grantees establish that recipients of services are legally residing in the United States. An exception to the contractual provision shall be allowed to address individuals presenting with emergent mental health conditions.

(3) The department shall require an annual report from the independent organizations that receive mental health services for special populations funding. The annual report, due January 1 of the current fiscal year, shall include specific information on services and programs provided, the client base to which the services and programs were provided, information on any wrap around services provided, and the expenditures for those services. The department shall provide the annual reports to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies.

Sec. 404. (1) Not later than May 31 of the current 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 that includes the information required by this section.

(2) The report shall contain information for each CMHSP or PIHP 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 that, minimally, includes a description of funding authorized; expenditures by client group and fund source; and cost information by service category, including administration. Service category includes all department-approved services.

(d) Data describing service outcomes that includes, but is not 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 that includes, but is not limited to, the following:

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

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

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

(g) An analysis of information provided by CMHSPs in response

to the needs assessment requirements of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106, including information about the number of individuals in the service delivery system who have requested and are clinically appropriate for different services.

(h) Lapses and carryforwards during the immediately preceding fiscal year for CMHSPs or PIHPs.

(i) Information about contracts for mental health services entered into by CMHSPs or PIHPs with providers, including, but not limited to, all of the following:

(*i*) The amount of the contract, organized by type of service provided.

(*ii*) Payment rates, organized by the type of service provided.

(*iii*) Administrative costs for services provided to CMHSPs or PIHPs.

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

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

(*ii*) Performance indicator information required to be submitted to the department in the contracts with CMHSPs or PIHPs.

(k) An estimate of the number of direct care workers in local residential settings and paraprofessional and other nonprofessional direct care workers in settings where skill building, community living supports and training, and personal care services are provided by CMHSPs or PIHPs as of September 30 of the prior fiscal

year employed directly or through contracts with provider organizations.

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

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

Sec. 407. (1) The amount appropriated in part 1 for substance abuse prevention, education, and treatment grants shall be expended for contracting with coordinating agencies. Coordinating agencies shall work with CMHSPs or PIHPs to coordinate care and services provided to individuals with severe and persistent mental illness and substance abuse diagnoses.

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

(3) It is the intent of the legislature that the coordinating agencies continue current efforts to collaborate on the delivery of services to those clients with mental illness and substance abuse diagnoses.

(4) Coordinating agencies that are located completely within the boundary of a PIHP shall conduct a study of the administrative costs and efficiencies associated with consolidation with that PIHP. If that coordinating agency realizes an administrative cost savings of 5% or greater of their current costs, then that coordinating agency shall initiate discussions regarding a

potential merger in accordance with section 6226 of the public health code, 1978 PA 368, MCL 333.6226. The department shall report to the legislature by April 1 of the current fiscal year on any such discussions.

Sec. 408. (1) By April 1 of the current fiscal year, the department shall report the following data from the prior fiscal year on substance abuse prevention, education, and treatment programs to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget office:

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

Sec. 412. The department shall contract directly with the Salvation Army harbor light program to provide non-Medicaid substance abuse services.

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

Sec. 424. Each PIHP that contracts with the department to provide services to the Medicaid population shall adhere to the following timely claims processing and payment procedure for claims submitted by health professionals and facilities:

(a) A "clean claim" as described in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i, shall be paid within 45 days after receipt of the claim by the PIHP. A clean claim that is not paid within this time frame shall bear simple interest at a rate of 12% per annum.

(b) A PIHP shall state in writing to the health professional or facility any defect in the claim within 30 days after receipt of the claim.

(c) A health professional and a health facility have 30 days

after receipt of a notice that a claim or a portion of a claim is defective within which to correct the defect. The PIHP shall pay the claim within 30 days after the defect is corrected.

Sec. 428. Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

Sec. 435. A county required under the provisions of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106, to provide matching funds to a CMHSP for mental health services rendered to residents in its jurisdiction shall pay the matching funds in equal installments on not less than a quarterly basis throughout the fiscal year, with the first payment being made by October 1 of the current fiscal year.

Sec. 442. (1) It is the intent of the legislature that the $32,056,100.00 in funding transferred from the community mental health non-Medicaid services line to support the Medicaid adult benefits waiver program shall be used to provide state match for increases in federal funding for primary care and specialty services provided to Medicaid adult benefits waiver enrollees and for economic increases for the Medicaid specialty services and supports program.

(2) The department shall assure that individuals enrolled in the Medicaid adult benefits waiver program shall receive mental

health services as approved in the state plan amendment.

(3) Capitation payments to CMHSPs for individuals who become enrolled in the Medicaid adult benefits waiver program shall be made using the same rate methodology as payments for the current Medicaid beneficiaries.

(4) If enrollment in the Medicaid adult benefits waiver program does not achieve expectations and the funding appropriated for the Medicaid adult benefits waiver program for specialty services is not expended, the general fund balance shall be transferred back to the community mental health non-Medicaid services line. The department shall report quarterly to the senate and house appropriations subcommittees on community health a summary of eligible expenditures for the Medicaid adult benefits waiver program by CMHSPs.

Sec. 458. By April 15 of the current fiscal year, the department shall provide each of the following to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director:

(a) An updated plan for implementing each of the recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004.

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. This report shall examine the potential impact that utilization of secure residential facilities would have upon the state's need for adult mental health facilities.

(c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

Sec. 462. (1) In order to implement the fiscal year 2011-2012 funding reduction to the community mental health non-Medicaid services line, the department shall further implement the funding formula that was partially implemented during fiscal year 2009-2010.

(2) The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the parameters used to make the fiscal year 2011-2012 funding formula adjustments as well as the impact of the formula on each CMHSP.

(3) In redetermining capitation rates for PIHPs in fiscal year 2011-2012, the department shall minimize the use of geographic factors.

Sec. 468. To foster a more efficient administration of and to integrate care in publicly funded mental health and substance abuse services, the department shall maintain criteria for the incorporation of a city, county, or regional substance abuse coordinating agency into a local community mental health authority that will encourage those city, county, or regional coordinating agencies to incorporate as local community mental health authorities. If necessary, the department may make accommodations or adjustments in formula distribution to address administrative

costs related to the maintenance of the criteria under this section and to the incorporation of the additional coordinating agencies into local community mental health authorities provided that all of the following are satisfied:

(a) The department provides funding for the administrative costs incurred by coordinating agencies incorporating into community mental health authorities. The department shall not provide more than $75,000.00 to any coordinating agency for administrative costs.

(b) The accommodations or adjustments favor coordinating agencies who voluntarily elect to integrate with local community mental health authorities.

(c) The accommodations or adjustments do not negatively affect other coordinating agencies.

Sec. 470. (1) For those substance abuse coordinating agencies that have voluntarily incorporated into community mental health authorities and accepted funding from the department for administrative costs incurred pursuant to section 468, the department shall establish written expectations for those CMHSPs, PIHPs, and substance abuse coordinating agencies and counties with respect to the integration of mental health and substance abuse services. At a minimum, the written expectations shall provide for the integration of those services as follows:

(a) Coordination and consolidation of administrative functions and redirection of efficiencies into service enhancements.

(b) Consolidation of points of 24-hour access for mental health and substance abuse services in every community.

(c) Alignment of coordinating agencies and PIHPs boundaries to maximize opportunities for collaboration and integration of administrative functions and clinical activities.

(2) By May 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office on the impact and effectiveness of this section and the status of the integration of mental health and substance abuse services.

Sec. 474. The department shall ensure that each contract with a CMHSP or PIHP requires the CMHSP or PIHP to provide each recipient and his or her family with information regarding the different types of guardianship and the alternatives to guardianship. A CMHSP or PIHP shall not, in any manner, attempt to reduce or restrict the ability of a recipient or his or her family from seeking to obtain any form of legal guardianship without just cause.

Sec. 480. The department shall provide to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by March 30 of the current fiscal year a report on the number and reimbursement cost of atypical antipsychotic prescriptions by each PIHP for Medicaid beneficiaries.

Sec. 489. The department shall work with the Michigan association of community mental health boards and individual CMHSPs in an effort to mitigate necessary reductions to the community mental health non-Medicaid services line by seeking alternative

funding sources.

Sec. 490. (1) The department shall establish a workgroup to develop a plan to maximize uniformity and consistency in the standards required of providers contracting directly with PIHPs, CMHSPs, and substance abuse coordinating agencies. These standards shall apply to community living supports, personal care services, substance abuse services, skill-building services, and other similar supports and services providers who contract with PIHPs, CMHSPs, and substance abuse coordinating agencies or their contractors.

(2) The workgroup shall include representatives of the department, PIHPs, CMHSPs, substance abuse coordinating agencies, and affected providers. The standards shall include, but are not limited to, contract language, training requirements for direct support staff, performance indicators, financial and program audits, and billing procedures.

(3) The department shall provide a status report on the workgroup's efforts to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director by June 1 of the current fiscal year.

Sec. 491. The department shall explore changes in program policy in the habilitation supports waiver for persons with developmental disabilities that would permit the movement of a slot that has become available to a county that has demonstrated a greater need for the services.

Sec. 492. If a CMHSP has entered into an agreement with a

county or county sheriff to provide mental health services to the inmates of the county jail, the department shall not prohibit the use of state general fund/general purpose dollars by CMHSPs to provide mental health services to inmates of a county jail.

Sec. 494. The department shall work with state approved national accrediting organizations, CMHSPs, and provider agencies to minimize the number of gaps between state requirements and national accrediting reviews during the accreditation process. The department shall report to the legislature by March 1 of the current fiscal year on the outcome of this effort.

Sec. 495. The population data used in determining the distribution of substance abuse block grant funds shall be from the most recent federal census.

Sec. 496. CMHSPs and PIHPs are permitted to offset state funding reductions by limiting the administrative component of their contracts with providers to a maximum of 9%.

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

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

(2) The department shall continue a revenue recapture project to generate additional revenues from third parties related to cases

that have been closed or are inactive. Revenues collected through project efforts shall be used for departmental costs and contractual fees associated with these retroactive collections and to improve ongoing departmental reimbursement management functions.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $1,000,000.00 remaining on September 30 of the current fiscal year from the amounts appropriated in part 1 for gifts and bequests for patient living and treatment environments shall be carried forward for 1 fiscal year. The purpose of gifts and bequests for patient living and treatment environments is to use additional private funds to provide specific enhancements for individuals residing at state-operated facilities. Use of the gifts and bequests shall be consistent with the stipulation of the donor. The expected completion date for the use of gifts and bequests donations is within 3 years unless otherwise stipulated by the donor.

Sec. 604. (1) The CMHSPs or PIHPs shall provide annual reports to the department on the following information:

(a) The number of days of care purchased from state hospitals and centers.

(b) The number of days of care purchased from private hospitals in lieu of purchasing days of care from state hospitals and centers.

(c) The number and type of alternative placements to state hospitals and centers other than private hospitals.

(d) Waiting lists for placements in state hospitals and centers.

(2) The department shall annually report the information in subsection (1) to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

Sec. 605. (1) The department shall not implement any closures or consolidations of state hospitals, centers, or agencies until CMHSPs or PIHPs have programs and services in place for those individuals currently in those facilities and a plan for service provision for those individuals who would have been admitted to those facilities.

(2) All closures or consolidations are dependent upon adequate department-approved CMHSP and PIHP plans that include a discharge and aftercare plan for each individual currently in the facility. A discharge and aftercare plan shall address the individual's housing needs. A homeless shelter or similar temporary shelter arrangements are inadequate to meet the individual's housing needs.

(3) Four months after the certification of closure required in section 19(6) of the state employees' retirement act, 1943 PA 240, MCL 38.19, the department shall provide a closure plan to the house and senate appropriations subcommittees on community health and the state budget director.

(4) Upon the closure of state-run operations and after transitional costs have been paid, the remaining balances of funds appropriated for that operation shall be transferred to CMHSPs or PIHPs responsible for providing services for individuals previously served by the operations.

Sec. 606. The department may collect revenue for patient

reimbursement from first- and third-party payers, including Medicaid and local county CMHSP payers, to cover the cost of placement in state hospitals and centers. The department is authorized to adjust financing sources for patient reimbursement based on actual revenues earned. If the revenue collected exceeds current year expenditures, the revenue may be carried forward with approval of the state budget director. The revenue carried forward shall be used as a first source of funds in the subsequent year.

Sec. 608. Effective October 1, 2010, the department, in consultation with the department of technology, management, and budget, shall establish and implement a bid process to identify 1 or more private contractors to provide food service and custodial services for the administrative areas at any state hospital identified by the department as capable of generating a minimum of 7.5% savings through the outsourcing of such services.

PUBLIC HEALTH ADMINISTRATION

Sec. 653. The department shall develop plans to address potential state public health emergencies.

HEALTH POLICY, REGULATION, AND PROFESSIONS

Sec. 704. The department shall continue to contract with grantees supported through the appropriation in part 1 for the emergency medical services grants and contracts to ensure that a sufficient number of qualified emergency medical services personnel exist to serve rural areas of the state.

Sec. 708. Nursing facilities shall report in the quarterly

staff report to the department, the total patient care hours provided each month, by state licensure and certification classification, and the percentage of pool staff, by state licensure and certification classification, used each month during the preceding quarter. The department shall make available to the public, the quarterly staff report compiled for all facilities including the total patient care hours and the percentage of pool staff used, by classification.

Sec. 709. The funds appropriated in part 1 for the Michigan essential health care provider program may also provide loan repayment for dentists that fit the criteria established by part 27 of the public health code, 1978 PA 368, MCL 333.2701 to 333.2727.

Sec. 711. The department may make available to interested entities customized listings of nonconfidential information in its possession, such as names and addresses of licensees. The department may establish and collect a reasonable charge to provide this service. The revenue received from this service shall be used to offset expenses to provide the service. Any balance of this revenue collected and unexpended at the end of the fiscal year shall revert to the appropriate restricted fund.

Sec. 714. The department shall report by April 1 of the current fiscal year to the legislature on the timeliness of nursing facility complaint investigations and the number of allegations that are substantiated on an annual basis. The report shall consist of the number of allegations filed by consumers and the number of facility-reported incidents. The department shall make every effort to contact every complainant and the subject of a complaint during

an investigation.

Sec. 716. The department shall give priority in investigations of alleged wrongdoing by licensed health care professionals to instances that are alleged to have occurred within 2 years of the initial complaint.

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

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

Sec. 726. (1) The department shall submit a report by April 1 of the current fiscal year to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director, on an annual basis, that includes all data on the amount collected from medical marihuana program application and renewal fees along with the cost of administering the medical marihuana program under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430.

(2) If the required fees are shown to be insufficient to offset all expenses of implementing and administering the medical marihuana program, the department shall review and revise the application and renewal fees accordingly to ensure that all expenses of implementing and administering the medical marihuana program are offset as is permitted under section 5 of the Michigan medical marihuana act, 2008 IL 1, MCL 333.26425.

Sec. 727. By October 1, 2011, the department shall establish and implement a bid process to identify a private or public contractor to provide management of the medical marihuana program. By January 1 of the current fiscal year, the department shall transfer responsibility for management of the medical marihuana program to the contractor identified by the bid process.

Sec. 729. The department shall identify counties in which there are an insufficient number of health professionals providing obstetrical and gynecological services. In addition, the department shall identify the reasons why there are an insufficient number of health professionals providing obstetrical and gynecological services and identify possible policy or fiscal, or both, measures considered necessary to address the shortage. The department shall submit a report of its findings under this section to the house and senate appropriations subcommittees on community health, house and senate fiscal agencies, and state budget director no later than December 1 of the current fiscal year.

INFECTIOUS DISEASE CONTROL

Sec. 801. In the expenditure of funds appropriated in part 1

for AIDS programs, the department and its subcontractors shall ensure that high-risk individuals ages 9 through 18 receive priority for prevention, education, and outreach services.

Sec. 803. The department shall continue the AIDS drug assistance program maintaining the prior year eligibility criteria and drug formulary. This section does not prohibit the department from providing assistance for improved AIDS treatment medications. If the appropriation in part 1 or actual revenue is not sufficient to maintain the prior year eligibility criteria and drug formulary, the department may revise the eligibility criteria and drug formulary in a manner that is consistent with federal program guidelines.

Sec. 805. The department shall continue to fund the Michigan care improvement registry at the same level as in fiscal year 2010-2011.

EPIDEMIOLOGY

Sec. 851. The department shall provide a report annually 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 is not limited to, a funding allocation schedule, expenditures by category of expenditure and by subcontractor, revenues received, description of program elements, and description of program accomplishments and progress.

LOCAL HEALTH ADMINISTRATION AND GRANTS

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

Sec. 902. (1) If a county that has participated in a district health department or an associated arrangement with other local health departments takes action to cease to participate in such an arrangement after October 1 of the current fiscal year, the department shall have the authority to assess a penalty from the local health department's operational accounts in an amount equal to no more than 6.25% of the local health department's essential local public health services funding. This penalty shall only be assessed to the local county that requests the dissolution of the health department.

(2) The department shall explore changes in program policy that would permit enhanced grants provided through the essential local public health services line to local public health departments that have successfully consolidated after October 1 of the current fiscal year.

Sec. 904. (1) Funds appropriated in part 1 for essential local public health services shall be prospectively allocated to local health departments to support immunizations, infectious disease control, sexually transmitted disease control and prevention,

hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management. Food protection shall be provided in consultation with the department of agriculture and rural development. Public water supply, private groundwater supply, and on-site sewage management shall be provided in consultation with the department of environmental quality.

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

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

(4) By April 1 of the current fiscal year, the department shall make available a report to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the planned allocation of the funds appropriated for essential local public health services.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Sec. 1006. In spending the funds appropriated in part 1 for the smoking prevention program, priority shall be given to prevention and smoking cessation programs for pregnant women, women with young children, and adolescents.

Sec. 1031. (1) From the funds appropriated in part 1 for the injury control intervention project, $170,000.00 shall be used to

continue 2 incentive-based pilot programs for level I and level II trauma hospitals to ensure greater state utilization of an interactive, evidence-based treatment guideline model for traumatic brain injury.

(2) One pilot program shall be placed in a county with a population of less than 225,000. The other pilot program shall be placed in a county with a population over 1,000,000.

FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES

Sec. 1103. (1) It is the intent of the legislature that, beginning March 31, 2013, the department shall issue a report to the legislature detailing user rates and public expenditures for family planning and sexual health. The report shall include at least the following expenditures of state and federal funds for the direct medical and clinical costs, as determined by the department, due to out-of-wedlock sexual activity:

(a) The percent of clients or users who are unmarried and access family planning, pregnancy prevention, or sexually transmitted disease prevention services.

(b) The approximate expenditure of state and federal funds, based on marital status, to provide family planning, pregnancy prevention, and sexually transmitted disease prevention services.

(c) The total annual public expenditure by the state, based on marital status, on medical care to persons who have contracted sexually transmitted diseases.

(d) The total annual public expenditure by the state for out-of-wedlock pregnancy, including prenatal care, birth expenses,

abortion expenses, and any expenditures the department determines may reasonably be related to pregnancy or pregnancy outcome for a period of 30 days after the date of delivery or termination of the pregnancy.

(2) Beginning on January 1 of the current fiscal year, the department shall begin gathering the data necessary to create the report described in subsection (1).

(3) The department may utilize or amend any other existing report to comply with the reporting requirement described in subsection (1) unless prohibited by law. It is the intent of the legislature that a service provider or agency that fails to comply with the reporting requirements in this section shall not be considered for funding for a period of at least 2 years.

Sec. 1104. (1) Before April 1 of the current fiscal year, the department shall submit a report to the house and senate fiscal agencies and the state budget director on planned allocations from the amounts appropriated in part 1 for local MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs. Using applicable federal definitions, the report shall include information on all of the following:

(a) Funding allocations.

(b) Actual number of women, children, and adolescents served and amounts expended for each group for the immediately preceding fiscal year.

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

(2) The department shall ensure that the distribution of funds through the programs described in subsection (1) takes into account the needs of rural communities.

(3) For the purposes of this section, "rural" means a county, city, village, or township with a population of 30,000 or less, including those entities if located within a metropolitan statistical area.

Sec. 1106. Each family planning program receiving federal title X family planning funds under 42 USC 300 to 300a-8 shall be in compliance with all performance and quality assurance indicators that the office of family planning within the United States department of health and human services specifies in the family planning annual report. An agency not in compliance with the indicators shall not receive supplemental or reallocated funds.

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

Sec. 1109. (1) From the amounts appropriated in part 1 for dental programs, funds shall be allocated to the Michigan dental association for the administration of a volunteer dental program that provides dental services to the uninsured.

(2) Not later than December 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house standing committees on health policy the number of individual patients treated, number of procedures performed, and approximate total market value of those procedures from the immediately preceding

fiscal year.

Sec. 1129. The department shall provide a report annually to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on the number of children with elevated blood lead levels from information available to the department. The report shall provide the information by county, shall include the level of blood lead reported, and shall indicate the sources of the information.

Sec. 1133. The department shall release infant mortality rate data to all local public health departments 72 hours or more before releasing infant mortality rate data to the public.

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

(a) The department of education.

(b) The department of community health.

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

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

(e) The department of human services.

(f) The department of state police.

(2) Upon written or oral request, a pupil not less than 18

years of age or a parent or legal guardian of a pupil less than 18 years of age, within a reasonable period of time after the request is made, shall be informed of the content of a course in the health education curriculum and may examine textbooks and other classroom materials that are provided to the pupil or materials that are presented to the pupil in the classroom. This subsection does not require a school board to permit pupil or parental examination of test questions and answers, scoring keys, or other examination instruments or data used to administer an academic examination.

WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Sec. 1153. The department shall ensure that individuals residing in rural communities have sufficient access to the services offered through the WIC program. The department shall report to the legislature on its efforts to increase access to the WIC program in rural areas.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

Sec. 1201. Funds appropriated in part 1 for medical care and treatment of children with special health care needs shall be paid according to reimbursement policies determined and published by the Michigan medical services administration.

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

Sec. 1204. By October 1, 2011, the department shall report to the senate and house appropriations committees on community health and the senate and house fiscal agencies on its plan for enrolling Medicaid eligible children's special health care services recipients in the Medicaid health plans. The report shall include information on which Medicaid health plans are participating, the methods used to assure continuity of care and continuity of ongoing relationships with providers, and projected savings from the implementation of the proposal.

CRIME VICTIM SERVICES COMMISSION

Sec. 1302. From the funds appropriated in part 1 for justice assistance grants, up to $200,000.00 shall be allocated for expansion of forensic nurse examiner programs to facilitate training for improved evidence collection for the prosecution of sexual assault. The funds shall be used for program coordination and training.

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

OFFICE OF SERVICES TO THE AGING

Sec. 1401. The appropriation in part 1 to the office of services to the aging for community services and nutrition 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.

Sec. 1403. (1) The office of services to the aging shall require each region to report to the office of services to the aging and to the legislature home-delivered meals waiting lists based upon standard criteria. Determining criteria shall include all of the following:

(a) The recipient's degree of frailty.

(b) The recipient's inability to prepare his or her own meals safely.

(c) Whether the recipient has another care provider available.

(d) Any other qualifications normally necessary for the recipient to receive home-delivered meals.

(2) Data required in subsection (1) shall be recorded only for individuals who have applied for participation in the home-delivered meals program and who are initially determined as likely to be eligible for home-delivered meals.

Sec. 1413. Local counties may request to change membership in the area agencies on aging if the change is to an area agency on aging that is contiguous to that county pursuant to office of services to the aging policies and procedures for area agency on aging designation. The office of services to the aging shall adjust allocations to area agencies on aging to account for any changes in

county membership. The office of services to the aging shall ensure annually that county boards of commissioners are aware that county membership in area agencies on aging can be changed subject to office of services to the aging policies and procedures for area agency on aging designation.

Sec. 1417. The department shall provide to the senate and house appropriations subcommittees on community health, senate and house fiscal agencies, and state budget director a report by March 30 of the current fiscal year that contains all of the following:

(a) The total allocation of state resources made to each area agency on aging by individual program and administration.

(b) Detail expenditure by each area agency on aging by individual program and administration including both state-funded resources and locally-funded resources.

Sec. 1418. From the funds appropriated in part 1 for nutrition services, the department shall maximize funding for home-delivered meals to the extent allowable under federal law and regulation.

Sec. 1420. The department shall create a pilot project to establish an aging care management services program with services provided solely by nurses. This pilot project shall be established in a county with a population greater than 150,000 but less than 250,000.

MEDICAL SERVICES

Sec. 1601. The cost of remedial services incurred by residents of licensed adult foster care homes and licensed homes for the aged shall be used in determining financial eligibility for the

medically needy. Remedial services include basic self-care and rehabilitation training for a resident.

Sec. 1603. (1) The department may establish a program for individuals 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.

(4) The department shall modify program policies to permit individuals eligible for the transitional medical assistance plus program, as structured in fiscal year 2009-2010, to access medical assistance coverage through a 100% cost share.

Sec. 1604. (1) A Medicaid recipient shall remain eligible and a qualifying applicant shall be determined eligible for medical assistance during a period of incarceration or detention. Medicaid coverage is limited during such a period to off-site inpatient hospitalization only.

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

Sec. 1605. 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.

Sec. 1606. For the purpose of guardian and conservator charges, the department of community health may deduct up to $60.00 per month as an allowable expense against a recipient's income when determining medical services eligibility and patient pay amounts.

Sec. 1607. (1) An applicant for Medicaid, whose qualifying condition is pregnancy, shall immediately be presumed to be eligible for Medicaid coverage unless the preponderance of evidence in her application indicates otherwise. The applicant who is qualified as described in this subsection shall be allowed to select or remain with the Medicaid participating obstetrician of her choice.

(2) An applicant qualified as described in subsection (1) shall be given a letter of authorization to receive Medicaid covered services related to her pregnancy. All qualifying applicants shall be entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from a health plan. All claims submitted for payment for obstetrical and prenatal care shall be paid at the Medicaid fee-for-service rate in the event a contract does not exist between the Medicaid participating obstetrical or prenatal care provider and the managed care plan. The applicant shall receive a listing of Medicaid physicians and managed care plans in the immediate vicinity of the applicant's residence.

(3) In the event that an applicant, presumed to be eligible pursuant to subsection (1), is subsequently found to be ineligible, a Medicaid physician or managed care plan that has been providing pregnancy services to an applicant under this section is entitled

to reimbursement for those services until such time as they are notified by the department that the applicant was found to be ineligible for Medicaid.

(4) If the preponderance of evidence in an application indicates that the applicant is not eligible for Medicaid, the department shall refer that applicant to the nearest public health clinic or similar entity as a potential source for receiving pregnancy-related services.

(5) The department shall develop an enrollment process for pregnant women covered under this section that facilitates the selection of a managed care plan at the time of application.

(6) The department shall mandate enrollment of women, whose qualifying condition is pregnancy, into Medicaid managed care plans.

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

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

Sec. 1611. (1) For care provided to medical services recipients with other third-party sources of payment, medical services reimbursement shall not exceed, in combination with such

other resources, including Medicare, those amounts established for medical services-only patients. The medical services payment rate shall be accepted as payment in full. Other than an approved medical services co-payment, no portion of a provider's charge shall be billed to the recipient or any person acting on behalf of the recipient. Nothing in this section shall be considered to affect the level of payment from a third-party source other than the medical services program. The department shall require a nonenrolled provider to accept medical services payments as payment in full.

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

Sec. 1620. (1) For fee-for-service recipients who do not reside in nursing homes, the pharmaceutical dispensing fee shall be $2.75 or the pharmacy's usual or customary cash charge, whichever is less. For nursing home residents, the pharmaceutical dispensing fee shall be $3.00 or the pharmacy's usual or customary cash charge, whichever is less.

(2) The department shall require a prescription co-payment for Medicaid recipients of $1.00 for a generic drug and $3.00 for a brand-name drug, except as prohibited by federal or state law or regulation.

(3) It is the intent of the legislature that if the department

realizes savings as a result of the implementation of average manufacturer's price for reimbursement of multiple source generic medication dispensing as imposed pursuant to the federal deficit reduction act of 2005, Public Law 109-171, the savings shall be returned to pharmacies in the form of an increased dispensing fee for medications not to exceed $2.00. The savings shall be calculated as the difference in state expenditure between the current methodology of payment, which is maximum allowable cost, and the proposed new reimbursement method of average manufacturer's price.

Sec. 1623. (1) The department shall continue the Medicaid policy that allows for the dispensing of a 100-day supply for maintenance drugs.

(2) The department shall notify all HMOs, physicians, pharmacies, and other medical providers that are enrolled in the Medicaid program that Medicaid policy allows for the dispensing of a 100-day supply for maintenance drugs.

(3) The notice in subsection (2) shall also clarify that a pharmacy shall fill a prescription written for maintenance drugs in the quantity specified by the physician, but not more than the maximum allowed under Medicaid, unless subsequent consultation with the prescribing physician indicates otherwise.

Sec. 1627. (1) The department shall use procedures and rebate amounts specified under section 1927 of title XIX, 42 USC 1396r-8, to secure quarterly rebates from pharmaceutical manufacturers for outpatient drugs dispensed to participants in the MIChild program, maternal outpatient medical services program, and children's

special health care services.

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

Sec. 1629. The department shall utilize maximum allowable cost pricing for generic drugs that is based on wholesaler pricing to providers that is available from at least 2 wholesalers who deliver in the state of Michigan.

Sec. 1630. Medicaid coverage for adult dental and podiatric services shall continue at not less than the level in effect on October 1, 2002, except that reasonable utilization limitations may be adopted in order to prevent excess utilization.

Sec. 1631. (1) The department shall require co-payments on dental, podiatric, and vision services provided to Medicaid recipients, except as prohibited by federal or state law or regulation.

(2) Except as otherwise prohibited by federal or state law or regulations, the department shall require Medicaid recipients to pay the following co-payments:

(a) Two dollars for a physician office visit.

(b) Three dollars for a hospital emergency room visit.

(c) Fifty dollars for the first day of an inpatient hospital stay.

(d) One dollar for an outpatient hospital visit.

Sec. 1635. From the funds appropriated in part 1 for physician services and health plan services, the department shall continue the increase in Medicaid reimbursement rates for obstetrical

services implemented in fiscal year 2005-2006.

Sec. 1636. From the funds appropriated in part 1 for physician services and health plan services, the department shall continue the increase in Medicaid reimbursement rates for physician well child procedure codes and primary care procedure codes implemented in fiscal year 2006-2007 and fiscal year 2008-2009. The increased reimbursement rates in this section shall not exceed the comparable Medicare payment rate for the same services.

Sec. 1641. An institutional provider that is required to submit a cost report under the medical services program shall submit cost reports completed in full within 5 months after the end of its fiscal year.

Sec. 1642. The department shall allow ambulatory surgery centers in this state to fully participate in the Medicaid program.

Sec. 1648. The department shall maintain and make available an online resource to enable medical providers to obtain enrollment and benefit information of Medicaid recipients. There shall be no charge to providers for the use of the online resource.

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

106-354.

Sec. 1650. (1) The department may require medical services recipients residing in counties offering managed care options to choose the particular managed care plan in which they wish to be enrolled. Individuals not expressing a preference may be assigned to a managed care provider.

(2) Individuals to be assigned a managed care provider shall be informed in writing of the criteria for exceptions to capitated managed care enrollment, their right to change HMOs for any reason within the initial 90 days of enrollment, the toll-free telephone number for problems and complaints, and information regarding grievance and appeals rights.

(3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the individual 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.

Sec. 1651. (1) Medical services patients who are enrolled in HMOs have the choice to elect hospice services or other services for the terminally ill that are offered by the HMOs. If the patient elects hospice services, those services shall be provided in accordance with part 214 of the public health code, 1978 PA 368, MCL 333.21401 to 333.21420.

(2) The department shall not amend the medical services hospice manual in a manner that would allow hospice services to be provided without making available all comprehensive hospice services described in 42 CFR part 418.

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

(a) The Medicaid HMO shall not sell, transfer, or otherwise convey to any person all or any portion of the HMO's assets or business, whether in the form of equity, debt or otherwise, for a period of 3 years from the date the Medicaid HMO commences operations in a new service area.

(b) That any Medicaid HMOs that expand into a county with a population of at least 1,500,000 shall also expand its coverage to a county with a population of less than 100,000 which has 1 or fewer HMOs participating in the Medicaid program.

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

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

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

(c) Mandatory enrollment of Medicaid beneficiaries living in counties defined as rural by the federal government, which is any nonurban standard metropolitan statistical area, is allowed if there is only 1 HMO serving the Medicaid population, as long as each Medicaid beneficiary is assured of having a choice of at least 2 physicians by the HMO.

(d) Enrollment of recipients of children's special health care services in HMOs shall continue to be voluntary for those enrolled in the children's special health care services program. Children's special health care services recipients shall be informed of the opportunity to enroll in HMOs.

(e) The department shall develop a case adjustment to its rate methodology that considers the costs of individuals with HIV/AIDS, end stage renal disease, organ transplants, and other high-cost diseases or conditions and shall implement the case adjustment when it is proven to be actuarially and fiscally sound. Implementation of the case adjustment shall be budget neutral.

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

Sec. 1654. Medicaid HMOs shall provide for reimbursement of HMO covered services delivered other than through the HMO's providers if medically necessary and approved by the HMO, immediately required, and that could not be reasonably obtained

through the HMO's providers on a timely basis. Such services shall be considered approved if the HMO does not respond to a request for authorization within 24 hours of the request. Reimbursement shall not exceed the Medicaid fee-for-service payment for those services.

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

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

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

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

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

(2) If the treating hospital determines that the recipient

will require further medical service or hospitalization beyond the point of stabilization, that hospital shall receive authorization from the recipient's HMO prior to admitting the recipient.

(3) Subsections (1) and (2) do not require an alteration to an existing agreement between an HMO and its contracting hospitals and do not require an HMO to reimburse for services that are not considered to be medically necessary.

Sec. 1658. (1) HMOs shall have contracts with hospitals within a reasonable distance from their enrollees. If a hospital does not contract with the HMO in its service area, that hospital shall enter into a hospital access agreement as specified in the Medical Services Administration Bulletin Hospital 01-19.

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

Sec. 1659. The following sections of this act are the only ones that shall apply to the following Medicaid managed care programs, including the comprehensive plan, MIChoice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 401, 402, 404, 418, 424, 428, 474, 1204, 1607, 1650, 1651, 1652, 1653, 1654, 1655, 1656, 1657, 1658, 1660, 1661, 1662, 1684, 1689, 1690, 1699, 1711, 1764, 1787, 1815, 1819, 1822, 1826, 1835, 1850, and 1853.

Sec. 1660. (1) The department shall assure that all Medicaid children have timely access to EPSDT services as required by federal law. Medicaid HMOs shall provide EPSDT services to their

child members in accordance with Medicaid EPSDT policy.

(2) The primary responsibility of assuring a child's hearing and vision screening is with the child's primary care provider. The primary care provider shall provide age-appropriate screening or arrange for these tests through referrals to local health departments. Local health departments shall provide preschool hearing and vision screening services and accept referrals for these tests from physicians or from Head Start programs in order to assure all preschool children have appropriate access to hearing and vision screening. Local health departments shall be reimbursed for the cost of providing these tests for Medicaid eligible children by the Medicaid program.

(3) The department shall prohibit HMOs from requiring prior authorization of their contracted providers for any EPSDT screening and diagnosis services.

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

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

Sec. 1661. (1) The department shall assure that all Medicaid eligible children and pregnant women have timely access to MIHP services. Medicaid HMOs shall assure that MIHP screening is available to their pregnant members and that those women found to meet the MIHP high-risk criteria are offered maternal support

services. Local health departments shall assure that MIHP screening is available for Medicaid pregnant women and that those women found to meet the MIHP high-risk criteria are offered MIHP services or are referred to a certified MIHP provider.

(2) The department shall require HMOs to be responsible for the coordination of MIHP services as described in Medicaid policy. These responsibilities shall be specified in the information distributed by the HMOs to their members.

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

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

Sec. 1662. (1) The department shall assure that an external quality review of each contracting HMO is performed that results in an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the HMO or its contractors furnish to Medicaid beneficiaries.

(2) The department shall require Medicaid HMOs to provide EPSDT utilization data through the encounter data system, and HEDIS well child health measures in accordance with the National Committee for Quality Assurance prescribed methodology.

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

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

(5) The department shall assure that training and technical assistance are available for EPSDT and MIHP for Medicaid health plans, local health departments, and MIHP contractors.

Sec. 1670. (1) The appropriation in part 1 for the MIChild program is to be used to provide comprehensive health care to all children under age 19 who reside in families with income at or below 200% of the federal poverty level, who are uninsured and have not had coverage by other comprehensive health insurance within 6 months of making application for MIChild benefits, and who are residents of this state. The department shall develop detailed eligibility criteria through the medical services administration public concurrence process, consistent with the provisions of this act. Health coverage for children in families between 150% and 200% of the federal poverty level shall be provided through a state-based private health care program.

(2) The department may provide up to 1 year of continuous

eligibility to children eligible for the MIChild program unless the family fails to pay the monthly premium, a child reaches age 19, or the status of the children's family changes and its members no longer meet the eligibility criteria as specified in the federally approved MIChild state plan.

(3) Children whose category of eligibility changes between the Medicaid and MIChild programs shall be assured of keeping their current health care providers through the current prescribed course of treatment for up to 1 year, subject to periodic reviews by the department if the beneficiary has a serious medical condition and is undergoing active treatment for that condition.

(4) To be eligible for the MIChild program, a child must be residing in a family with an adjusted gross income of less than or equal to 200% of the federal poverty level. The department's verification policy shall be used to determine eligibility.

(5) The department shall enter into a contract to obtain MIChild services from any HMO, dental care corporation, or any other entity that offers to provide the managed health care benefits for MIChild services at the MIChild capitated rate. As used in this subsection:

(a) "Dental care corporation", "health care corporation", "insurer", and "prudent purchaser agreement" mean those terms as defined in section 2 of the prudent purchaser act, 1984 PA 233, MCL 550.52.

(b) "Entity" means a health care corporation or insurer operating in accordance with a prudent purchaser agreement.

(6) The department may enter into contracts to obtain certain

MIChild services from community mental health service programs.

(7) The department may make payments on behalf of children enrolled in the MIChild program from the line-item appropriation associated with the program as described in the MIChild state plan approved by the United States department of health and human services, or from other medical services.

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

(9) The department shall develop an automatic enrollment algorithm that is based on quality and performance factors.

Sec. 1673. The department may establish premiums for MIChild eligible individuals in families with income above 150% of the federal poverty level. The monthly premiums shall not be less than $10.00 or exceed $15.00 for a family.

Sec. 1682. (1) The department shall implement enforcement actions as specified in the nursing facility enforcement provisions of section 1919 of title XIX, 42 USC 1396r.

(2) In addition to the appropriations in part 1, the department is authorized to receive and spend penalty money received as the result of noncompliance with medical services certification regulations. Penalty money, characterized as private funds, received by the department shall increase authorizations and allotments in the long-term care accounts.

(3) The department is authorized to provide civil monetary

penalty funds to the disability network/Michigan to be distributed to the 15 centers for independent living for the purpose of assisting individuals with disabilities who reside in nursing homes to return to their own homes.

(4) The department is authorized to use civil monetary penalty funds to conduct a survey evaluating consumer satisfaction and the quality of care at nursing homes. Factors can include, but are not limited to, the level of satisfaction of nursing home residents, their families, and employees. The department may use an independent contractor to conduct the survey.

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

Sec. 1684. The department shall submit a report by September 30 of the current fiscal year to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director that will identify by waiver agent, Medicaid home- and community-based services waiver costs by administration, case management, and direct services.

Sec. 1685. All nursing home rates, class I and class III, shall 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. 1689. (1) Priority in enrolling additional individuals in the Medicaid home- and community-based services waiver program shall be given to those who are currently residing in nursing homes or who are eligible to be admitted to a nursing home if they are not provided home- and community-based services. The department shall use screening and assessment procedures to assure that no additional Medicaid eligible individuals are admitted to nursing homes who would be more appropriately served by the Medicaid home- and community-based services waiver program.

(2) Within 60 days of the end of each fiscal year, the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies that details existing and future allocations for the home- and community-based services waiver program by regions as well as the associated expenditures. The report shall include information regarding the net cost savings from moving individuals from a nursing home to the home- and community-based services waiver program, the number of individuals transitioned from nursing homes to the home- and community-based services waiver program, the number of individuals on waiting lists by region for the program, and the amount of funds transferred during the fiscal year. The report shall also include the number of Medicaid individuals served and the number of days of care for the home- and community-based services waiver program and in nursing homes.

(3) The department shall develop a system to collect and

analyze information regarding individuals on the home- and community-based services waiver program waiting list to identify the community supports they receive, including, but not limited to, adult home help, food assistance, and housing assistance services and to determine the extent to which these community supports help individuals remain in their home and avoid entry into a nursing home. The department shall provide a progress report on implementation to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by June 1 of the current fiscal year.

(4) The department shall maintain any policies, guidelines, procedures, standards, and regulations in order to limit the self-determination option with respect to the home- and community-based services waiver program to those services furnished by approved home-based service providers meeting provider qualifications established in the waiver and approved by the centers for Medicare and Medicaid services.

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

(2) The department shall submit a report to the house and senate appropriations subcommittees on community health, the house

and senate fiscal agencies, and the state budget director by April 1 of the current fiscal year, to include all data collected on the quality assurance indicators in the preceding fiscal year for the adult home help program, as well as quality improvement plans and data collected on critical incidents in the adult home help program and their resolutions.

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

(2) From the funds appropriated in part 1 for medical services school-based 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.

Sec. 1693. (1) The special Medicaid reimbursement appropriation in part 1 may be increased if the department submits

a medical services state plan amendment pertaining to this line item at a level higher than the appropriation. The department is authorized to appropriately adjust financing sources in accordance with the increased appropriation.

(2) The department shall ensure that all public entities eligible for special Medicaid reimbursement that participate in the Medicaid program are aware of the existence of these programs.

Sec. 1694. The department shall distribute $1,122,300.00 to an academic health care system that includes a children's hospital that has a high indigent care volume.

Sec. 1699. (1) The department may make separate payments in the amount of $45,000,100.00 directly to qualifying hospitals serving a disproportionate share of indigent patients and to hospitals providing GME training programs. If direct payment for GME and DSH is made to qualifying hospitals for services to Medicaid clients, hospitals shall not include GME costs or DSH payments in their contracts with HMOs.

(2) The department shall allocate $45,000,000.00 in DSH funding using the distribution methodology used in fiscal year 2003-2004.

(3) The department shall allocate $100.00 in DSH funding to unaffiliated hospitals and hospital systems that received less than $900,000.00 in DSH payments in fiscal year 2007-2008 based on a formula that is weighted proportional to the product of each eligible system's Medicaid revenue and each eligible system's Medicaid utilization, except that no payment of less than $1,000.00 shall be made.

(4) By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the new distribution of funding to each eligible hospital from the GME and DSH pools.

(5) The department shall form a workgroup on DSH funding consisting of representatives from hospitals and hospital systems receiving DSH funding and the Michigan health and hospital association. The workgroup shall work to derive a new DSH formula or formulas designed to provide equitable payments to qualifying hospitals. The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the results of the workgroup's efforts by March 1 of the current fiscal year.

Sec. 1711. The department shall maintain the 2-tier reimbursement methodology for Medicaid emergency physicians professional services that was in effect on September 30, 2002.

Sec. 1712. (1) Subject to the availability of funds, the department shall implement a rural health initiative. Available funds shall first be allocated as an outpatient adjustor payment to be paid directly to hospitals in rural counties in proportion to each hospital's Medicaid and indigent patient population. Additional funds, if available, shall be allocated for defibrillator grants, emergency medical technician training and support, or other similar programs.

(2) Except as otherwise specified in this section, "rural" means a county, city, village, or township with a population of not

more than 30,000, including those entities if located within a metropolitan statistical area.

Sec. 1718. The department shall provide each Medicaid adult home help beneficiary or applicant with the right to a fair hearing when the department or its agent reduces, suspends, terminates, or denies adult home help services. If the department takes action to reduce, suspend, terminate, or deny adult home help services, it shall provide the beneficiary or applicant with a written notice that states what action the department proposes to take, the reasons for the intended action, the specific regulations that support the action, and an explanation of the beneficiary's or applicant's right to an evidentiary hearing and the circumstances under which those services will be continued if a hearing is requested.

Sec. 1724. The department shall allow licensed pharmacies to purchase injectable drugs for the treatment of respiratory syncytial virus for shipment to physicians' offices to be administered to specific patients. If the affected patients are Medicaid eligible, the department shall reimburse pharmacies for the dispensing of the injectable drugs and reimburse physicians for the administration of the injectable drugs.

Sec. 1731. The department shall continue an asset test to determine Medicaid eligibility for individuals who are parents, caretaker relatives, or individuals between the ages of 18 and 21 and who are not required to be covered under federal Medicaid requirements.

Sec. 1741. The department shall continue to provide nursing

homes the opportunity to receive interim payments upon their request. The department shall make efforts to ensure that the interim payments are as similar to expected cost-settled payments as possible.

Sec. 1757. (1) The department shall direct the department of human services to obtain proof from all Medicaid recipients that they are legal United States citizens or otherwise legally residing in this country and that they are residents of this state before approving Medicaid eligibility.

(2) It is the intent of the legislature that the department seek clarification from the federal government on whether states can deny Medicaid eligibility to fugitive felons through a state plan amendment or waiver. The department shall report to the legislature on the results of this effort.

Sec. 1764. The department shall annually certify rates paid to Medicaid health plans as being actuarially sound in accordance with federal requirements and shall provide a copy of the rate certification and approval immediately to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies.

Sec. 1767. The department shall study and evaluate the impact of the change in the way in which the Medicaid program pays pharmacists for prescriptions from average wholesale price to average manufacturer price as required by the federal deficit reduction act of 2005, Public Law 109-171. Upon release of the data by the centers for Medicare and Medicaid services, the department shall submit a report of its study to the senate and house

appropriations subcommittees on community health and the senate and house fiscal agencies. If the department finds that there is a negative impact on the pharmacists, the department shall reexamine the current pharmaceutical dispensing fee structure established under section 1620 and include in the report recommendations and proposals to counter the negative impact of that federal legislation.

Sec. 1770. In conjunction with the consultation requirements of the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, and except as otherwise provided in this section, the department shall attempt to make the effective date for a proposed Medicaid policy bulletin or adjustment to the Medicaid provider manual on October 1, January 1, April 1, or July 1 after the end of the consultation period. The department may provide an effective date for a proposed Medicaid policy bulletin or adjustment to the Medicaid provider manual other than provided for in this section if necessary to be in compliance with federal or state law, regulations, or rules or with an executive order of the governor.

Sec. 1775. If the state's application for a waiver to implement managed care for dual Medicare/Medicaid eligible is approved by the federal government, by April 1, 2012 the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies. This report shall include information on the amount of Medicare funding that would be provided to the state as a block grant, the number of individuals who would be enrolled in the program, which Medicaid health plans that would be participating,

and the estimated savings from the new program.

Sec. 1777. From the funds appropriated in part 1 for long-term care services, the department shall permit, in accordance with applicable federal and state law, nursing homes to use dining assistants to feed eligible residents if legislation to permit the use of dining assistants is enacted into law. The department shall not be responsible for costs associated with training dining assistants.

Sec. 1787. The department shall require the managed care enrollment broker to maintain telephone numbers of Medicaid beneficiaries and provide each Medicaid health plan with the telephone number of that health plan's enrollees on a monthly basis.

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

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

Sec. 1815. From the funds appropriated in part 1 for health plan services, the department shall not implement a capitation withhold as part of the overall capitation rate schedule that exceeds the 0.19% withhold administered during fiscal year 2008-2009.

Sec. 1817. The department shall report to the legislature on

implementation of a policy that will prohibit billing for care made necessary by preventable medical errors or adverse health events no later than April 1 of the current fiscal year.

Sec. 1819. The department shall use Medicaid health plan encounter data in the development and revision of hospital diagnosis related group pricing policy.

Sec. 1822. The department, the department's contracted Medicaid pharmacy benefit manager, and all Medicaid health plans shall implement coverage for a mental health prescription drug within 30 days of that drug's approval by the department's pharmacy and therapeutics committee.

Sec. 1826. The department shall develop a plan to expand and improve the beneficiary monitoring program. This plan shall include cost-effective methods to monitor and reduce unnecessary health care services, including prescription drugs, improve coordination of services between the primary care physician and mental health and substance abuse service providers, and improve compliance with prescribed medical management to reduce more costly use of emergency services. The department shall submit this plan to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by April 1 of the current fiscal year.

Sec. 1829. Notwithstanding the removal of coverage for certain optional Medicaid services, the department shall continue its policy of providing coverage for emergency services. For this purpose, the department shall continue to adhere to the guidelines outlined in Medical Services Administration Bulletin MSA 09-28.

Sec. 1832. (1) The department shall continue efforts to standardize billing formats, referral forms, electronic credentialing, primary source verification, electronic billing and attachments, claims status, eligibility verification, and reporting of accepted and rejected encounter records received in the department data warehouse.

(2) The department shall convene a workgroup on making e-billing mandatory for the Medicaid program. The workgroup shall include representatives from medical provider organizations, Medicaid HMOs, and the department. The department shall report to the legislature on the findings of the workgroup by April 1 of the current fiscal year.

(3) The department shall provide a report by April 1 of the current fiscal year to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies detailing the percentage of claims for Medicaid reimbursement provided to the department that were initially rejected in the first quarter of fiscal year 2011-2012.

Sec. 1835. The department shall develop and implement processes to report rejected and accepted encounters to Medicaid health plans. Medicaid health plans shall be permitted to report additional medical records data obtained during medical record audits to the encounter warehouse consistent with Medicare guidelines.

Sec. 1836. In addition to the guidelines established in Medical Services Administration Bulletin MSA 09-28, medically necessary optical devices and other treatment services for adult

Medicaid patients shall be covered when conventional treatments do not provide functional vision correction. Such ocular conditions include, but are not limited to, congenital or acquired ocular disease or eye trauma.

Sec. 1837. The department shall explore utilization of telemedicine as a strategy to increase access to primary care services for Medicaid recipients in medically underserved areas.

Sec. 1842. (1) Subject to the availability of funds, the department shall adjust the hospital outpatient Medicaid reimbursement rate for qualifying hospitals as provided in this section. The Medicaid reimbursement rate for qualifying hospitals shall be adjusted to provide each qualifying hospital with its actual cost of delivering outpatient services to Medicaid recipients.

(2) As used in this section, "qualifying hospital" means a hospital that has not more than 50 staffed beds and is either located outside a metropolitan statistical area or in a metropolitan statistical area but within a city, village, or township with a population of not more than 12,000 according to the official 2000 federal decennial census and within a county with a population of not more than 165,000 according to the official 2000 federal decennial census.

Sec. 1847. (1) The department shall collect and report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies the following information by March 1 of the current fiscal year:

(a) The number and percentage of medical residents by hospital

who were residents of Michigan prior to beginning their residency.

(b) The number and percentage of medical residents by hospital who took positions in the state of Michigan during 2011 immediately following completion of their residency.

(c) The distribution of these in-state placements by county and by specialty.

(d) The distribution of graduated medical residents in medically underserved areas by physician specialty.

(2) It is the intent of the legislature that Medicaid graduate medical education payments in fiscal year 2012-2013 shall be made using a formula that incorporates the data reported in subsection (1).

Sec. 1848. (1) A hospital or freestanding surgical outpatient facility may report whether a registered nurse, qualified by training and experience in operating room nursing, is present as a circulating nurse in each separate operating room where surgery is being performed for the duration of the operative procedure. This section does not preclude a circulating nurse from leaving the operating room as part of the procedure, leaving the operating room as part of the operative procedure, leaving the operating room for short periods, or, in accordance with employer rules or regulations, being relieved during an operative procedure by another circulating nurse assigned to continue the operative procedure.

(2) The department shall report any data collected pursuant to subsection (1) on the use of a circulating nurse in the operating room of hospitals and freestanding surgical outpatient facilities

to the legislature on an annual basis. The circulating nurse shall assist administration in assuring regulatory compliance data are collected, including the verification of the circulating nurse.

Sec. 1849. (1) The department may use 50% of the funds allocated for voluntary in-home visiting services for evidence-based models.

(2) As used in this section:

(a) "Evidence-based" means a program or practice that meets both of the following requirements:

(*i*) The program or practice is governed by a program manual or protocol that specifies the nature, quality, and amount of service that constitutes the program.

(*ii*) Scientific research using methods that meet high scientific standards for evaluating the effects of the program must have demonstrated, with 2 or more separate client samples, that the program improves client outcomes central to the purpose of the program.

(b) "In-home visiting services" means a service delivery strategy that is carried out in the homes of families or children from conception to school age that provides culturally sensitive face-to-face visits by nurses or other professionals trained to promote positive parenting practices, enhance the socio-emotional and cognitive development of children, improve health of the family, and empower the family to be self-sufficient.

Sec. 1850. The department shall allow Medicaid health plans to assist with the redetermination process through outreach activities to ensure continuation of Medicaid eligibility and enrollment in

managed care. This may include mailings, telephone contact, or face-to-face contact with beneficiaries enrolled in the individual Medicaid health plan. Health plans may offer assistance in completing paperwork for beneficiaries enrolled in their plan.

Sec. 1851. The department is encouraged to consider seeking bids for statewide or regional contracts for Medicaid durable medical equipment services.

Sec. 1852. The department shall work with the department of energy, labor, and economic growth to integrate fully state inspections of nursing facilities.

Sec. 1853. The department shall form a workgroup composed of representatives from the Medicaid HMOs and the Michigan association of health plans to develop revisions to the process of automatically assigning new Medicaid recipients to HMOs if they do not choose an HMO upon enrollment. The department shall report on the results of the workgroup's findings to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by March 1 of the current fiscal year.

Sec. 1854. The department shall work with a provider of kidney dialysis services and renal care products that has completed a centers for Medicare and Medicaid services end stage renal disease management demonstration project to design and implement a statewide chronic kidney disease management program as authorized under section 2703 of the patient protection and affordable care act, Public Law 111-148. The department shall work with the provider to develop a chronic condition health home program for Medicaid enrollees identified with chronic kidney disease and

transitioning through the first 3 months of dialysis. The department and the provider will create metrics for the measurement of the program that include both cost savings and clinical improvement. The department shall report to the senate and house appropriations subcommittees on community health to provide progress updates on compliance with this section.

Sec. 1855. The department is encouraged to consider the feasibility of a revenue-neutral, financially risk-averse Medicaid patient optimization solution for the support of emergency department redirection for non-emergent patients.

Sec. 1856. If funds become available it is the intent of the legislature that funding for graduate medical education be increased.

PART 2A

PROVISIONS CONCERNING ANTICIPATED APPROPRIATIONS FOR FISCAL YEAR 2012-2013

GENERAL SECTIONS

Sec. 1901. It is the intent of the legislature to provide appropriations for the fiscal year ending on September 30, 2013 for the line items listed in part 1. The fiscal year 2012-2013 appropriations are anticipated to be the same as those for fiscal year 2011-2012, except that the line items will be adjusted for changes in caseload and related costs, federal fund match rates, economic factors, and available revenue. These adjustments will be determined after the January 2012 consensus revenue estimating

conference. The January 2012 consensus revenue estimating conference shall include estimates for fiscal year 2011-2012, fiscal year 2012-2013, and fiscal year 2013-2014 for the following:

(a) State revenue.

(b) Prison population and correction expenditures.

(c) Annual percentage growth in the school aid basic foundation allowance.

(d) Medicaid expenditures.

(e) Human service caseloads and expenditures.