

HOUSE SUBSTITUTE FOR
SENATE BILL NO. 897

A bill to amend 1939 PA 280, entitled
"The social welfare act,"
by amending section 105d (MCL 400.105d), as added by 2013 PA 107,
and by adding sections 107a and 107b.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 105d. (1) The department ~~of community health~~ shall seek a
2 waiver from the United States ~~department of health and human~~
3 ~~services~~ **DEPARTMENT OF HEALTH AND HUMAN SERVICES** to do, without
4 jeopardizing federal match dollars or otherwise incurring federal
5 financial penalties, and upon approval of the waiver shall do, all
6 of the following:

7 (a) Enroll individuals eligible under section

1 1396a(a)(10)(A)(i)(VIII) of title XIX who meet the citizenship
2 provisions of 42 CFR 435.406 and who are otherwise eligible for the
3 medical assistance program under this act into a contracted health
4 plan that provides for an account into which money from any source,
5 including, but not limited to, the enrollee, the enrollee's
6 employer, and private or public entities on the enrollee's behalf,
7 can be deposited to pay for incurred health expenses, including,
8 but not limited to, co-pays. The account shall be administered by
9 the department ~~of community health~~ and can be delegated to a
10 contracted health plan or a third party administrator, as
11 considered necessary. ~~The department of community health shall not~~
12 ~~begin enrollment of individuals eligible under this subdivision~~
13 ~~until January 1, 2014 or until the waiver requested in this~~
14 ~~subsection is approved by the United States department of health~~
15 ~~and human services, whichever is later.~~

16 (b) Ensure that contracted health plans track all enrollee co-
17 pays incurred for the first 6 months that an individual is enrolled
18 in the program described in subdivision (a) and calculate the
19 average monthly co-pay experience for the enrollee. The average co-
20 pay amount shall be adjusted at least annually to reflect changes
21 in the enrollee's co-pay experience. The department ~~of community~~
22 ~~health~~ shall ensure that each enrollee receives quarterly
23 statements for his or her account that include expenditures from
24 the account, account balance, and the cost-sharing amount due for
25 the following 3 months. The enrollee shall be required to remit
26 each month the average co-pay amount calculated by the contracted
27 health plan into the enrollee's account. The department ~~of~~

1 ~~community health~~ shall pursue a range of consequences for enrollees
2 who consistently fail to meet their cost-sharing requirements,
3 including, but not limited to, using the MICHild program as a
4 template and closer oversight by health plans in access to
5 providers. ~~The department of community health shall report its plan~~
6 ~~of action for enrollees who consistently fail to meet their cost-~~
7 ~~sharing requirements to the legislature by June 1, 2014.~~

8 (c) Give enrollees described in subdivision (a) a choice in
9 choosing among contracted health plans.

10 (d) Ensure that all enrollees described in subdivision (a)
11 have access to a primary care practitioner who is licensed,
12 registered, or otherwise authorized to engage in his or her health
13 care profession in this state and to preventive services. The
14 ~~department of community health~~ shall require that all new enrollees
15 be assigned and have scheduled an initial appointment with their
16 primary care practitioner within 60 days of initial enrollment. The
17 ~~department of community health~~ shall monitor and track contracted
18 health plans for compliance in this area and consider that
19 compliance in any health plan incentive programs. The department of
20 ~~community health~~ shall ensure that the contracted health plans have
21 procedures to ensure that the privacy of the enrollees' personal
22 information is protected in accordance with the health insurance
23 portability and accountability act of 1996, Public Law 104-191.

24 (e) Require enrollees described in subdivision (a) with annual
25 incomes between 100% and 133% of the federal poverty guidelines to
26 contribute not more than 5% of income annually for cost-sharing
27 requirements. Cost-sharing includes co-pays and required

1 contributions made into the accounts authorized under subdivision
2 (a). Contributions required in this subdivision do not apply for
3 the first 6 months an individual described in subdivision (a) is
4 enrolled. Required contributions to an account used to pay for
5 incurred health expenses shall be 2% of income annually.

6 ~~Notwithstanding~~ **EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (20)**,
7 **NOTWITHSTANDING** this minimum, required contributions may be reduced
8 by the contracting health plan. The reductions may occur only if
9 healthy behaviors are being addressed as attested to by the
10 contracted health plan based on uniform standards developed by the
11 department of ~~community health~~ in consultation with the contracted
12 health plans. The uniform standards shall include healthy behaviors
13 ~~that must include, but are not limited to,~~ **SUCH AS** completing a
14 department of ~~community health~~ approved annual health risk
15 assessment to identify unhealthy characteristics, including alcohol
16 use, substance use disorders, tobacco use, obesity, and
17 immunization status. ~~Co-pays~~ **EXCEPT AS OTHERWISE PROVIDED IN**
18 **SUBSECTION (20)**, **CO-PAYS** can be reduced if healthy behaviors are
19 met, but not until annual accumulated co-pays reach 2% of income
20 except co-pays for specific services may be waived by the
21 contracted health plan if the desired outcome is to promote greater
22 access to services that prevent the progression of and
23 complications related to chronic diseases. If the enrollee
24 described in subdivision (a) becomes ineligible for medical
25 assistance under the program described in this section, the
26 remaining balance in the account described in subdivision (a) shall
27 be returned to that enrollee in the form of a voucher for the sole

1 purpose of purchasing and paying for private insurance.

2 (f) ~~By July 1, 2014, design and implement~~ **IMPLEMENT** a co-pay
3 structure that encourages use of high-value services, while
4 discouraging low-value services such as nonurgent emergency
5 department use.

6 (g) During the enrollment process, inform enrollees described
7 in subdivision (a) about advance directives and require the
8 enrollees to complete a ~~department of community health approved~~
9 **DEPARTMENT-APPROVED** advance directive on a form that includes an
10 option to decline. The advance directives received from enrollees
11 as provided in this subdivision shall be transmitted to the peace
12 of mind registry organization to be placed on the peace of mind
13 registry.

14 (h) ~~By April 1, 2015, develop~~ **DEVELOP** incentives for enrollees
15 and providers who assist the department ~~of community health~~ in
16 detecting fraud and abuse in the medical assistance program. The
17 department ~~of community health~~ shall provide an annual report that
18 includes the type of fraud detected, the amount saved, and the
19 outcome of the investigation to the legislature.

20 (i) Allow for services provided by telemedicine from a
21 practitioner who is licensed, registered, or otherwise authorized
22 under section 16171 of the public health code, 1978 PA 368, MCL
23 333.16171, to engage in his or her health care profession in the
24 state where the patient is located.

25 (2) For services rendered to an uninsured individual, a
26 hospital that participates in the medical assistance program under
27 this act shall accept 115% of ~~medicare~~ **MEDICARE** rates as payments

1 in full from an uninsured individual with an annual income level up
2 to 250% of the federal poverty guidelines. This subsection applies
3 whether or not either or both of the waivers requested under this
4 section are approved, the patient protection and affordable care
5 act is repealed, or the state terminates or opts out of the program
6 established under this section.

7 (3) Not more than 7 calendar days after receiving each of the
8 official waiver-related written correspondence from the United
9 States ~~department of health and human services~~ **DEPARTMENT OF HEALTH**
10 **AND HUMAN SERVICES** to implement the provisions of this section, the
11 ~~department of community health~~ shall submit a written copy of the
12 approved waiver provisions to the legislature for review.

13 (4) ~~By September 30, 2015, the~~ **THE** ~~department of community~~
14 ~~health~~ shall develop and implement a plan to enroll all existing
15 fee-for-service enrollees into contracted health plans if allowable
16 by law, if the medical assistance program is the primary payer and
17 if that enrollment is cost-effective. This includes all newly
18 eligible enrollees as described in subsection (1)(a). The
19 ~~department of community health~~ shall include contracted health
20 plans as the mandatory delivery system in its waiver request. The
21 ~~department of community health~~ also shall pursue any and all
22 necessary waivers to enroll persons eligible for both ~~medicaid~~
23 **MEDICAID** and ~~medicare~~ **MEDICARE** into the 4 integrated care
24 demonstration regions. ~~beginning July 1, 2014. By September 30,~~
25 ~~2015, the~~ **THE** ~~department of community health~~ shall identify all
26 remaining populations eligible for managed care, develop plans for
27 their integration into managed care, and provide recommendations

1 for a performance bonus incentive plan mechanism for long-term care
2 managed care providers that are consistent with other managed care
3 performance bonus incentive plans. ~~By September 30, 2015, the~~ **THE**
4 ~~department of community health~~ shall make recommendations for a
5 performance bonus incentive plan for long-term care managed care
6 providers of up to 3% of their ~~medicaid~~ **MEDICAID** capitation
7 payments, consistent with other managed care performance bonus
8 incentive plans. These payments shall comply with federal
9 requirements and shall be based on measures that identify the
10 appropriate use of long-term care services and that focus on
11 consumer satisfaction, consumer choice, and other appropriate
12 quality measures applicable to community-based and nursing home
13 services. Where appropriate, these quality measures shall be
14 consistent with quality measures used for similar services
15 implemented by the integrated care for duals demonstration project.
16 This subsection applies whether or not either or both of the
17 waivers requested under this section are approved, the patient
18 protection and affordable care act is repealed, or the state
19 terminates or opts out of the program established under this
20 section.

21 (5) ~~By September 30, 2016, the~~ **THE** department of ~~community~~
22 ~~health~~ shall implement a pharmaceutical benefit that utilizes co-
23 pays at appropriate levels allowable by the ~~centers~~ **CENTERS** for
24 ~~medicare and medicaid services~~ **MEDICARE AND MEDICAID SERVICES** to
25 encourage the use of high-value, low-cost prescriptions, such as
26 generic prescriptions when such an alternative exists for a branded
27 product and 90-day prescription supplies, as recommended by the

1 enrollee's prescribing provider and as is consistent with section
2 109h and sections 9701 to 9709 of the public health code, 1978 PA
3 368, MCL 333.9701 to 333.9709. This subsection applies whether or
4 not either or both of the waivers requested under this section are
5 approved, the patient protection and affordable care act is
6 repealed, or the state terminates or opts out of the program
7 established under this section.

8 (6) The department ~~of community health~~ shall work with
9 providers, contracted health plans, and other departments as
10 necessary to create processes that reduce the amount of uncollected
11 cost-sharing and reduce the administrative cost of collecting cost-
12 sharing. To this end, a minimum 0.25% of payments to contracted
13 health plans shall be withheld for the purpose of establishing a
14 cost-sharing compliance bonus pool beginning October 1, 2015. The
15 distribution of funds from the cost-sharing compliance pool shall
16 be based on the contracted health plans' success in collecting
17 cost-sharing payments. The department ~~of community health~~ shall
18 develop the methodology for distribution of these funds. This
19 subsection applies whether or not either or both of the waivers
20 requested under this section are approved, the patient protection
21 and affordable care act is repealed, or the state terminates or
22 opts out of the program established under this section.

23 (7) ~~By June 1, 2014, the~~ **THE** department ~~of community health~~
24 shall develop a methodology that decreases the amount an enrollee's
25 required contribution may be reduced as described in subsection
26 (1)(e) based on, but not limited to, factors such as an enrollee's
27 failure to pay cost-sharing requirements and the enrollee's

1 inappropriate utilization of emergency departments.

2 (8) The program described in this section is created in part
3 to extend health coverage to the state's low-income citizens and to
4 provide health insurance cost relief to individuals and to the
5 business community by reducing the cost shift attendant to
6 uncompensated care. Uncompensated care does not include courtesy
7 allowances or discounts given to patients. The ~~medicaid~~ **MEDICAID**
8 hospital cost report shall be part of the uncompensated care
9 definition and calculation. In addition to the ~~medicaid~~ **MEDICAID**
10 hospital cost report, the department ~~of community health~~ shall
11 collect and examine other relevant financial data for all hospitals
12 and evaluate the impact that providing medical coverage to the
13 expanded population of enrollees described in subsection (1)(a) has
14 had on the actual cost of uncompensated care. This shall be
15 reported for all hospitals in the state. By December 31, 2014, the
16 department ~~of community health~~ shall make an initial baseline
17 uncompensated care report containing at least the data described in
18 this subsection to the legislature and each December 31 after that
19 shall make a report regarding the preceding fiscal year's evidence
20 of the reduction in the amount of the actual cost of uncompensated
21 care compared to the initial baseline report. The baseline report
22 shall use fiscal year 2012-2013 data. Based on the evidence of the
23 reduction in the amount of the actual cost of uncompensated care
24 borne by the hospitals in this state, ~~beginning April 1, 2015,~~ the
25 department ~~of community health~~ shall proportionally reduce the
26 disproportionate share payments to all hospitals and hospital
27 systems for the purpose of producing general fund savings. The

1 department of ~~community health~~ shall recognize any savings from
2 this reduction by September 30, 2016. All the reports required
3 under this subsection shall be made available to the legislature
4 and shall be easily accessible on the ~~department of community~~
5 ~~health's~~ **DEPARTMENT'S** website.

6 (9) The department of insurance and financial services shall
7 examine the financial reports of health insurers and evaluate the
8 impact that providing medical coverage to the expanded population
9 of enrollees described in subsection (1)(a) has had on the cost of
10 uncompensated care as it relates to insurance rates and insurance
11 rate change filings, as well as its resulting net effect on rates
12 overall. The department of insurance and financial services shall
13 consider the evaluation described in this subsection in the annual
14 approval of rates. By December 31, 2014, the department of
15 insurance and financial services shall make an initial baseline
16 report to the legislature regarding rates and each December 31
17 after that shall make a report regarding the evidence of the change
18 in rates compared to the initial baseline report. All the reports
19 required under this subsection shall be made available to the
20 legislature and shall be made available and easily accessible on
21 the ~~department of community health's~~ **DEPARTMENT'S** website.

22 (10) The department of ~~community health~~ shall explore and
23 develop a range of innovations and initiatives to improve the
24 effectiveness and performance of the medical assistance program and
25 to lower overall health care costs in this state. The department of
26 ~~community health~~ shall report the results of the efforts described
27 in this subsection to the legislature and to the house and senate

1 fiscal agencies by September 30, 2015. The report required under
2 this subsection shall also be made available and easily accessible
3 on the ~~department of community health's~~ **DEPARTMENT'S** website. The
4 ~~department of community health~~ shall pursue a broad range of
5 innovations and initiatives as time and resources allow that shall
6 include, at a minimum, all of the following:

7 (a) The value and cost-effectiveness of optional ~~medicaid~~
8 **MEDICAID** benefits as described in federal statute.

9 (b) The identification of private sector, primarily small
10 business, health coverage benefit differences compared to the
11 medical assistance program services and justification for the
12 differences.

13 (c) The minimum measures and data sets required to effectively
14 measure the medical assistance program's return on investment for
15 taxpayers.

16 (d) Review and evaluation of the effectiveness of current
17 incentives for contracted health plans, providers, and
18 beneficiaries with recommendations for expanding and refining
19 incentives to accelerate improvement in health outcomes, healthy
20 behaviors, and cost-effectiveness and review of the compliance of
21 required contributions and co-pays.

22 (e) Review and evaluation of the current design principles
23 that serve as the foundation for the state's medical assistance
24 program to ensure the program is cost-effective and that
25 appropriate incentive measures are utilized. The review shall
26 include, at a minimum, the auto-assignment algorithm and
27 performance bonus incentive pool. This subsection applies whether

1 or not either or both of the waivers requested under this section
2 are approved, the patient protection and affordable care act is
3 repealed, or the state terminates or opts out of the program
4 established under this section.

5 (f) The identification of private sector initiatives used to
6 incent individuals to comply with medical advice.

7 (11) By December 31, 2015, the department ~~of community health~~
8 shall review and report to the legislature the feasibility of
9 programs recommended by multiple national organizations that
10 include, but are not limited to, the council of state governments,
11 the national conference of state legislatures, and the American
12 legislative exchange council, on improving the cost-effectiveness
13 of the medical assistance program.

14 (12) ~~By January 1, 2014, the~~ **THE** department ~~of community~~
15 ~~health~~ in collaboration with the contracted health plans and
16 providers shall create financial incentives for all of the
17 following:

18 (a) Contracted health plans that meet specified population
19 improvement goals.

20 (b) Providers who meet specified quality, cost, and
21 utilization targets.

22 (c) Enrollees who demonstrate improved health outcomes or
23 maintain healthy behaviors as identified in a health risk
24 assessment as identified by their primary care practitioner who is
25 licensed, registered, or otherwise authorized to engage in his or
26 her health care profession in this state. This subsection applies
27 whether or not either or both of the waivers requested under this

1 section are approved, the patient protection and affordable care
2 act is repealed, or the state terminates or opts out of the program
3 established under this section.

4 (13) ~~By October 1, 2015, the~~ **THE** performance bonus incentive
5 pool for contracted health plans that are not specialty prepaid
6 health plans shall include inappropriate utilization of emergency
7 departments, ambulatory care, contracted health plan all-cause
8 acute 30-day readmission rates, and generic drug utilization when
9 such an alternative exists for a branded product and consistent
10 with section 109h and sections 9701 to 9709 of the public health
11 code, 1978 PA 368, MCL 333.9701 to 333.9709, as a percentage of
12 total. These measurement tools shall be considered and weighed
13 within the 6 highest factors used in the formula. This subsection
14 applies whether or not either or both of the waivers requested
15 under this section are approved, the patient protection and
16 affordable care act is repealed, or the state terminates or opts
17 out of the program established under this section.

18 (14) The department ~~of community health~~ shall ensure that all
19 capitated payments made to contracted health plans are actuarially
20 sound. This subsection applies whether or not either or both of the
21 waivers requested under this section are approved, the patient
22 protection and affordable care act is repealed, or the state
23 terminates or opts out of the program established under this
24 section.

25 (15) The department ~~of community health~~ shall maintain
26 administrative costs at a level of not more than 1% of the
27 ~~department of community health's~~ **DEPARTMENT'S** appropriation of the

1 state medical assistance program. These administrative costs shall
2 be capped at the total administrative costs for the fiscal year
3 ending September 30, 2016, except for inflation and project-related
4 costs required to achieve medical assistance net general fund
5 savings. This subsection applies whether or not either or both of
6 the waivers requested under this section are approved, the patient
7 protection and affordable care act is repealed, or the state
8 terminates or opts out of the program established under this
9 section.

10 (16) ~~By October 1, 2015, the~~ **THE** department of ~~community~~
11 ~~health~~ shall establish uniform procedures and compliance metrics
12 for utilization by the contracted health plans to ensure that cost-
13 sharing requirements are being met. This shall include
14 ramifications for the contracted health plans' failure to comply
15 with performance or compliance metrics. This subsection applies
16 whether or not either or both of the waivers requested under this
17 section are approved, the patient protection and affordable care
18 act is repealed, or the state terminates or opts out of the program
19 established under this section.

20 (17) ~~Beginning October 1, 2015, the~~ **THE** department of ~~of~~
21 ~~community health~~ shall withhold, at a minimum, 0.75% of payments to
22 contracted health plans, except for specialty prepaid health plans,
23 for the purpose of expanding the existing performance bonus
24 incentive pool. Distribution of funds from the performance bonus
25 incentive pool is contingent on the contracted health plan's
26 completion of the required performance or compliance metrics. This
27 subsection applies whether or not either or both of the waivers

1 requested under this section are approved, the patient protection
2 and affordable care act is repealed, or the state terminates or
3 opts out of the program established under this section.

4 (18) ~~By October 1, 2015, the~~ **THE** department of ~~community~~
5 ~~health~~ shall withhold, at a minimum, 0.75% of payments to specialty
6 prepaid health plans for the purpose of establishing a performance
7 bonus incentive pool. Distribution of funds from the performance
8 bonus incentive pool is contingent on the specialty prepaid health
9 plan's completion of the required performance of compliance metrics
10 ~~, which~~ **THAT** shall include, at a minimum, partnering with other
11 contracted health plans to reduce nonemergent emergency department
12 utilization, increased participation in patient-centered medical
13 homes, increased use of electronic health records and data sharing
14 with other providers, and identification of enrollees who may be
15 eligible for services through the ~~veterans administration.~~ **UNITED**
16 **STATES DEPARTMENT OF VETERANS AFFAIRS.** This subsection applies
17 whether or not either or both of the waivers requested under this
18 section are approved, the patient protection and affordable care
19 act is repealed, or the state terminates or opts out of the program
20 established under this section.

21 (19) The department of ~~community health~~ shall measure
22 contracted health plan or specialty prepaid health plan performance
23 metrics, as applicable, on application of standards of care as that
24 relates to appropriate treatment of substance use disorders and
25 efforts to reduce substance use disorders. This subsection applies
26 whether or not either or both of the waivers requested under this
27 section are approved, the patient protection and affordable care

1 act is repealed, or the state terminates or opts out of the program
2 established under this section.

3 (20) By ~~September 1, 2015,~~ **OCTOBER 1, 2018**, in addition to the
4 waiver requested in subsection (1), the department of ~~community~~
5 ~~health~~ shall seek an additional waiver from the United States
6 ~~department of health and human services~~ **DEPARTMENT OF HEALTH AND**
7 **HUMAN SERVICES** that requires individuals who are between 100% and
8 133% of the federal poverty guidelines and who have had medical
9 assistance coverage for 48 cumulative months beginning on the date
10 of their enrollment into the program described in subsection (1) **BY**
11 **THE DATE OF THE WAIVER IMPLEMENTATION** to choose 1 of the following
12 options:

13 ~~—— (a) Change their medical assistance program eligibility~~
14 ~~status, in accordance with federal law, to be considered eligible~~
15 ~~for federal advance premium tax credit and cost sharing subsidies~~
16 ~~from the federal government to purchase private insurance coverage~~
17 ~~through an American health benefit exchange without financial~~
18 ~~penalty to the state.~~

19 ~~—— (b) Remain in the medical assistance program but increase~~
20 ~~cost sharing requirements up to 7% of income. Required~~
21 ~~contributions shall be deposited into an account used to pay for~~
22 ~~incurred health expenses for covered benefits and shall be 3.5% of~~
23 ~~income but may be reduced as provided in subsection (1)(c). The~~
24 ~~department of community health may reduce co pays as provided in~~
25 ~~subsection (1)(c), but not until annual accumulated co pays reach~~
26 ~~3% of income.~~

27 **(A) COMPLETE A HEALTHY BEHAVIOR AS PROVIDED IN SUBSECTION**

1 (1) (E) WITH INTENTIONAL EFFORT GIVEN TO MAKING SUBSEQUENT YEAR
2 HEALTHY BEHAVIORS INCREMENTALLY MORE CHALLENGING IN ORDER TO
3 CONTINUE TO FOCUS ON ELIMINATING HEALTH-RELATED OBSTACLES
4 INHIBITING ENROLLEES FROM ACHIEVING THEIR HIGHEST LEVELS OF
5 PERSONAL PRODUCTIVITY AND PAY A PREMIUM OF 5% OF INCOME. A REQUIRED
6 CONTRIBUTION FOR A PREMIUM IS NOT ELIGIBLE FOR REDUCTION OR REFUND.

7 (B) SUSPEND ELIGIBILITY FOR THE PROGRAM DESCRIBED IN
8 SUBSECTION (1) (A) UNTIL THE INDIVIDUAL COMPLIES WITH SUBDIVISION
9 (A) .

10 (21) The department ~~of community health~~ shall notify enrollees
11 60 days before the ~~end of the enrollee's forty eighth month that~~
12 **ENROLLEE WOULD LOSE** coverage under the current program **THAT THIS**
13 **COVERAGE** is no longer available to them and that, in order to
14 continue coverage, the enrollee must ~~choose between the options~~
15 **COMPLY WITH THE OPTION** described in subsection (20) (a) . ~~or (b) .~~

16 ~~— (22) The department of community health shall implement a~~
17 ~~system for individuals who fail to choose an option described under~~
18 ~~subsection (20) (a) or (b) within a specified time determined by the~~
19 ~~department of community health that enrolls those individuals into~~
20 ~~the option described in subsection (20) (b) .~~

21 (22) THE MEDICAL COVERAGE FOR INDIVIDUALS DESCRIBED IN
22 SUBSECTION (1) (A) SHALL REMAIN IN EFFECT FOR NOT LONGER THAN A 16-
23 MONTH PERIOD AFTER SUBMISSION OF A NEW OR AMENDED WAIVER REQUEST
24 UNDER SUBSECTION (20) IF A NEW OR AMENDED WAIVER REQUEST IS NOT
25 APPROVED WITHIN 12 MONTHS AFTER SUBMISSION. THE DEPARTMENT MUST
26 NOTIFY INDIVIDUALS DESCRIBED IN SUBSECTION (1) (A) THAT THEIR
27 COVERAGE WILL BE TERMINATED BY FEBRUARY 1, 2020 IF A NEW OR AMENDED

1 **WAIVER REQUEST IS NOT APPROVED WITHIN 12 MONTHS AFTER SUBMISSION.**

2 ~~—— (23) If the waiver requested under subsection (20) is not~~
3 ~~approved by the United States department of health and human~~
4 ~~services by December 31, 2015, medical coverage for individuals~~
5 ~~described in subsection (1) (a) shall no longer be provided. If the~~
6 ~~waiver is not approved by December 31, 2015, then by January 31,~~
7 ~~2016, the department of community health shall notify enrollees~~
8 ~~that the program described in subsection (1) shall be terminated on~~
9 ~~April 30, 2016. If a waiver requested under subsection (1) or (20)~~
10 ~~is approved and is required to be renewed at any time after~~
11 ~~approval, medical coverage for individuals described in subsection~~
12 ~~(1) (a) shall no longer be provided if either renewal request is not~~
13 ~~approved by the United States department of health and human~~
14 ~~services or if a waiver is canceled after approval. The department~~
15 ~~of community health shall give enrollees 4 months' advance notice~~
16 ~~before termination of coverage based on a renewal request not being~~
17 ~~approved as described in this subsection. A notification described~~
18 ~~in this subsection shall state that the enrollment was terminated~~
19 ~~due to the failure of the United States department of health and~~
20 ~~human services to approve the waiver requested under subsection~~
21 ~~(20) or renewal of a waiver described in this subsection.~~

22 **(23) IF A NEW OR AMENDED WAIVER REQUESTED UNDER SUBSECTION**
23 **(20) IS DENIED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN**
24 **SERVICES, MEDICAL COVERAGE FOR INDIVIDUALS DESCRIBED IN SUBSECTION**
25 **(1) (A) SHALL REMAIN IN EFFECT FOR A 16-MONTH PERIOD AFTER THE DATE**
26 **OF SUBMISSION OF THE NEW OR AMENDED WAIVER REQUEST UNLESS THE**
27 **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES APPROVES A**

1 NEW OR AMENDED WAIVER DESCRIBED IN THIS SUBSECTION WITHIN THE 12
2 MONTHS AFTER THE DATE OF SUBMISSION OF THE NEW OR AMENDED WAIVER
3 REQUEST. A REQUEST FOR A NEW OR AMENDED WAIVER UNDER THIS
4 SUBSECTION MUST COMPLY WITH THE OTHER REQUIREMENTS OF THIS SECTION
5 AND MUST BE PROVIDED TO THE CHAIRS OF THE SENATE AND HOUSE OF
6 REPRESENTATIVES APPROPRIATIONS COMMITTEES AND THE CHAIRS OF THE
7 SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON
8 THE DEPARTMENT BUDGET, AT LEAST 30 DAYS BEFORE SUBMISSION TO THE
9 UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. IF A NEW OR
10 AMENDED WAIVER REQUEST UNDER THIS SUBSECTION IS NOT APPROVED WITHIN
11 THE 12-MONTH PERIOD DESCRIBED IN THIS SUBSECTION, THE DEPARTMENT
12 MUST GIVE 4 MONTHS' NOTICE THAT MEDICAL COVERAGE FOR INDIVIDUALS
13 DESCRIBED IN SUBSECTION (1) (A) SHALL BE TERMINATED.

14 (24) IF A NEW OR AMENDED WAIVER REQUESTED UNDER SUBSECTION
15 (20) IS CANCELED BY THE UNITED STATES DEPARTMENT OF HEALTH AND
16 HUMAN SERVICES OR IS INVALIDATED, MEDICAL COVERAGE FOR INDIVIDUALS
17 DESCRIBED IN SUBSECTION (1) (A) SHALL REMAIN IN EFFECT FOR 16 MONTHS
18 AFTER THE DATE OF SUBMISSION OF A NEW OR AMENDED WAIVER UNLESS THE
19 UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES APPROVES A
20 NEW OR AMENDED WAIVER DESCRIBED IN THIS SUBSECTION WITHIN THE 12
21 MONTHS AFTER THE DATE OF SUBMISSION OF THE NEW OR AMENDED WAIVER. A
22 REQUEST FOR A NEW OR AMENDED WAIVER UNDER THIS SUBSECTION MUST
23 COMPLY WITH THE OTHER REQUIREMENTS OF THIS SECTION AND MUST BE
24 PROVIDED TO THE CHAIRS OF THE SENATE AND HOUSE OF REPRESENTATIVES
25 APPROPRIATIONS COMMITTEES AND THE SENATE AND HOUSE OF
26 REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON THE DEPARTMENT
27 BUDGET AT LEAST 30 DAYS BEFORE SUBMISSION TO THE UNITED STATES

1 DEPARTMENT OF HEALTH AND HUMAN SERVICES. IF A NEW OR AMENDED WAIVER
2 UNDER THIS SUBSECTION IS NOT APPROVED WITHIN THE 12-MONTH PERIOD
3 DESCRIBED IN THIS SUBSECTION, THE DEPARTMENT MUST GIVE 4 MONTHS'
4 NOTICE THAT MEDICAL COVERAGE FOR INDIVIDUALS DESCRIBED IN
5 SUBSECTION (1) (A) SHALL BE TERMINATED.

6 (25) IF A NEW OR AMENDED WAIVER REQUEST UNDER SUBSECTION (23)
7 OR (24) IS APPROVED BY THE UNITED STATES DEPARTMENT OF HEALTH AND
8 HUMAN SERVICES BUT DOES NOT COMPLY WITH THE OTHER REQUIREMENTS OF
9 THIS SECTION, MEDICAL COVERAGE FOR INDIVIDUALS DESCRIBED IN
10 SUBSECTION (1) (A) SHALL BE TERMINATED 4 MONTHS AFTER THE NEW OR
11 AMENDED WAIVER HAS BEEN DETERMINED TO BE IN NONCOMPLIANCE. THE
12 DEPARTMENT MUST NOTIFY INDIVIDUALS DESCRIBED IN SUBSECTION (1) (A)
13 AT LEAST 4 MONTHS BEFORE THE TERMINATION DATE THAT ENROLLMENT SHALL
14 BE TERMINATED AND THE REASON FOR TERMINATION.

15 (26) ~~(24)~~—Individuals described in 42 CFR 440.315 are not
16 subject to the provisions of the waiver described in subsection
17 (20).

18 (27) ~~(25)~~—The department of ~~community health~~ shall make
19 available at least 3 years of state medical assistance program
20 data, without charge, to any vendor considered qualified by the
21 department of ~~community health~~ who indicates interest in submitting
22 proposals to contracted health plans in order to implement cost
23 savings and population health improvement opportunities through the
24 use of innovative information and data management technologies. Any
25 program or proposal to the contracted health plans must be
26 consistent with the state's goals of improving health, increasing
27 the quality, reliability, availability, and continuity of care, and

1 reducing the cost of care of the eligible population of enrollees
2 described in subsection (1) (a). The use of the data described in
3 this subsection for the purpose of assessing the potential
4 opportunity and subsequent development and submission of formal
5 proposals to contracted health plans is not a cost or contractual
6 obligation to the department of community health or the state.

7 ~~—— (26) If the department of community health does not receive~~
8 ~~approval for both of the waivers required under this section before~~
9 ~~December 31, 2015, the program described in this section is~~
10 ~~terminated. The department of community health shall request~~
11 ~~written documentation from the United States department of health~~
12 ~~and human services that if the waivers described in this section~~
13 ~~are rejected causing the medical assistance program to revert back~~
14 ~~to the eligibility requirements in effect on the effective date of~~
15 ~~the amendatory act that added this section, excluding any waivers~~
16 ~~that have not been renewed, there shall be no financial federal~~
17 ~~funding penalty to the state associated with the implementation and~~
18 ~~subsequent cancellation of the program created in this section. If~~
19 ~~the department of community health does not receive this~~
20 ~~documentation by December 31, 2013, the department of community~~
21 ~~health shall not implement the program described in this section.~~

22 (28) ~~(27)~~ This section does not apply if either of the
23 following occurs:

24 (a) If the department of community health is unable to obtain
25 either of the federal waivers requested in subsection (1) or (20).

26 (b) If federal government matching funds for the program
27 described in this section are reduced below 100% and annual state

Senate Bill No. 897 as amended June 6, 2018

1 savings and other nonfederal net savings associated with the
2 implementation of that program are not sufficient to cover the
3 reduced federal match. The department ~~of community health~~ shall
4 determine and the state budget office shall approve how annual
5 state savings and other nonfederal net savings shall be calculated
6 by June 1, 2014. By September 1, 2014, the calculations and
7 methodology used to determine the state and other nonfederal net
8 savings shall be submitted to the legislature. **[THE CALCULATION OF ANNUAL
STATE AND OTHER NONFEDERAL NET SAVINGS SHALL BE PUBLISHED ANNUALLY ON
JANUARY 15 BY THE STATE BUDGET OFFICE. IF THE ANNUAL STATE SAVINGS AND
OTHER NONFEDERAL NET SAVINGS ARE NOT SUFFICIENT TO COVER THE REDUCED
FEDERAL MATCH, MEDICAL COVERAGE FOR INDIVIDUALS DESCRIBED IN SUBSECTION
(1) (A) SHALL REMAIN IN EFFECT UNTIL THE END OF THE FISCAL YEAR IN WHICH
THE CALCULATION DESCRIBED IN THIS SUBDIVISION IS PUBLISHED BY THE STATE
BUDGET OFFICE.]**

9 (29) ~~(28)~~ The department ~~of community health~~ shall develop,
10 administer, and coordinate with the department of treasury a
11 procedure for offsetting the state tax refunds of an enrollee who
12 owes a liability to the state of past due uncollected cost-sharing,
13 as allowable by the federal government. The procedure shall include
14 a guideline that the department ~~of community health~~ submit to the
15 department of treasury, not later than November 1 of each year, all
16 requests for the offset of state tax refunds claimed on returns
17 filed or to be filed for that tax year. For the purpose of this
18 subsection, any nonpayment of the cost-sharing required under this
19 section owed by the enrollee is considered a liability to the state
20 under section 30a(2)(b) of 1941 PA 122, MCL 205.30a.

21 (30) ~~(29)~~ For the purpose of this subsection, any nonpayment
22 of the cost-sharing required under this section owed by the
23 enrollee is considered a current liability to the state under
24 section 32 of the McCauley-Traxler-Law-Bowman-McNeely lottery act,
25 1972 PA 239, MCL 432.32, and shall be handled in accordance with
26 the procedures for handling a liability to the state under that
27 section, as allowed by the federal government.

1 (31) ~~(30)~~ By November 30, 2013, the department of ~~community~~
2 ~~health~~ shall convene a symposium to examine the issues of emergency
3 department overutilization and improper usage. ~~By December 31,~~
4 ~~2014, the~~ **THE** department of ~~community health~~ shall submit a report
5 to the legislature that identifies the causes of overutilization
6 and improper emergency service usage that includes specific best
7 practice recommendations for decreasing overutilization of
8 emergency departments and improper emergency service usage, as well
9 as how those best practices are being implemented. Both broad
10 recommendations and specific recommendations related to the
11 ~~medicaid~~ **MEDICAID** program, enrollee behavior, and health plan
12 access issues shall be included.

13 (32) ~~(31)~~ The department of ~~community health~~ shall contract
14 with an independent third party vendor to review the reports
15 required in subsections (8) and (9) and other data as necessary, in
16 order to develop a methodology for measuring, tracking, and
17 reporting medical cost and uncompensated care cost reduction or
18 rate of increase reduction and their effect on health insurance
19 rates along with recommendations for ongoing annual review. The
20 final report and recommendations shall be submitted to the
21 legislature by September 30, 2015.

22 (33) ~~(32)~~ For the purposes of submitting reports and other
23 information or data required under this section only, "legislature"
24 means the senate majority leader, the speaker of the house of
25 representatives, the chairs of the senate and house of
26 representatives appropriations committees, the chairs of the senate
27 and house of representatives appropriations subcommittees on the

1 department of ~~community health~~ budget, and the chairs of the senate
2 and house of representatives standing committees on health policy.

3 (34) ~~(33)~~ As used in this section:

4 (a) "Patient protection and affordable care act" means the
5 patient protection and affordable care act, Public Law 111-148, as
6 amended by the federal health care and education reconciliation act
7 of 2010, Public Law 111-152.

8 (b) "Peace of mind registry" and "peace of mind registry
9 organization" mean those terms as defined in section 10301 of the
10 public health code, 1978 PA 368, MCL 333.10301.

11 (c) "State savings" means any state fund net savings,
12 calculated as of the closing of the financial books for the
13 department of ~~community health~~ at the end of each fiscal year, that
14 result from the program described in this section. The savings
15 shall result in a reduction in spending from the following state
16 fund accounts: adult benefit waiver, ~~non-medicaid~~ **NON-MEDICAID**
17 community mental health, and prisoner health care. Any identified
18 savings from other state fund accounts shall be proposed to the
19 house of representatives and senate appropriations committees for
20 approval to include in that year's state savings calculation. It is
21 the intent of the legislature that for fiscal year ending September
22 30, 2014 only, \$193,000,000.00 of the state savings shall be
23 deposited in the roads and risks reserve fund created in section
24 211b of article VIII of 2013 PA 59.

25 (d) "Telemedicine" means that term as defined in section 3476
26 of the insurance code of 1956, 1956 PA 218, MCL 500.3476.

27 **SEC. 107A. (1) THE PURPOSE OF ADDING WORKFORCE ENGAGEMENT**

1 REQUIREMENTS TO THE MEDICAL ASSISTANCE PROGRAM AS PROVIDED IN
2 SECTION 107B IS TO ASSIST, ENCOURAGE, AND PREPARE AN ABLE-BODIED
3 ADULT FOR A LIFE OF SELF-SUFFICIENCY AND INDEPENDENCE FROM
4 GOVERNMENT INTERFERENCE.

5 (2) AS USED IN THIS SECTION AND SECTION 107B:

6 (A) "ABLE-BODIED ADULT" MEANS AN INDIVIDUAL AT LEAST 19 TO 62
7 YEARS OF AGE WHO IS NOT PREGNANT AND WHO DOES NOT HAVE A DISABILITY
8 THAT MAKES HIM OR HER ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SECTION
9 105D.

10 (B) "CARETAKER" MEANS A PARENT OR AN INDIVIDUAL WHO IS TAKING
11 CARE OF A CHILD IN THE ABSENCE OF A PARENT OR AN INDIVIDUAL CARING
12 FOR A DISABLED INDIVIDUAL AS DESCRIBED IN SECTION 107B(1)(F)(v). A
13 CARETAKER IS NOT SUBJECT TO THE WORKFORCE ENGAGEMENT REQUIREMENTS
14 ESTABLISHED UNDER SECTION 107B IF HE OR SHE IS NOT A MEDICAL
15 ASSISTANCE RECIPIENT UNDER SECTION 105D.

16 (C) "CHILD" MEANS AN INDIVIDUAL WHO IS NOT EMANCIPATED UNDER
17 1968 PA 293, MCL 722.1 TO 722.6, WHO LIVES WITH A PARENT OR
18 CARETAKER, AND WHO IS EITHER OF THE FOLLOWING:

19 (i) UNDER THE AGE OF 18.

20 (ii) AGE 18 AND A FULL-TIME HIGH SCHOOL STUDENT.

21 (D) "GOOD CAUSE TEMPORARY EXEMPTION" MEANS:

22 (i) THE RECIPIENT IS AN INDIVIDUAL WITH A DISABILITY AS
23 DESCRIBED IN SUBTITLE A OF TITLE II OF THE AMERICANS WITH
24 DISABILITIES ACT OF 1990, 42 USC 12131 TO 12134, SECTION 504 OF
25 TITLE V OF THE REHABILITATION ACT OF 1973, 29 USC 794, OR SECTION
26 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW
27 111-148, WHO IS UNABLE TO MEET THE WORKFORCE ENGAGEMENT

1 REQUIREMENTS FOR REASONS RELATED TO THAT DISABILITY.

2 (ii) THE RECIPIENT HAS AN IMMEDIATE FAMILY MEMBER IN THE HOME
3 WITH A DISABILITY UNDER FEDERAL DISABILITY RIGHTS LAWS AND IS
4 UNABLE TO MEET THE WORKFORCE ENGAGEMENT REQUIREMENTS FOR REASONS
5 RELATED TO THE DISABILITY OF THAT FAMILY MEMBER.

6 (iii) THE RECIPIENT OR AN IMMEDIATE FAMILY MEMBER, WHO IS
7 LIVING IN THE HOME WITH THE RECIPIENT, EXPERIENCES HOSPITALIZATION
8 OR SERIOUS ILLNESS.

9 (E) "INCAPACITATED INDIVIDUAL" MEANS THAT TERM AS DEFINED IN
10 SECTION 1105 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA
11 386, MCL 700.1105.

12 (F) "MEDICALLY FRAIL" MEANS THAT TERM AS DESCRIBED IN 42 CFR
13 440.315(F).

14 (G) "QUALIFYING ACTIVITY" MEANS ANY OF THE FOLLOWING:

15 (i) EMPLOYMENT OR SELF-EMPLOYMENT, OR HAVING INCOME CONSISTENT
16 WITH BEING EMPLOYED OR SELF-EMPLOYED. AS USED IN THIS SUBPARAGRAPH,
17 "HAVING INCOME CONSISTENT WITH BEING EMPLOYED OR SELF-EMPLOYED"
18 MEANS AN INDIVIDUAL MAKES AT LEAST MINIMUM WAGE FOR AN AVERAGE OF
19 80 HOURS PER MONTH.

20 (ii) EDUCATION DIRECTLY RELATED TO EMPLOYMENT, INCLUDING, BUT
21 NOT LIMITED TO, HIGH SCHOOL EQUIVALENCY TEST PREPARATION PROGRAM
22 AND POSTSECONDARY EDUCATION.

23 (iii) JOB TRAINING DIRECTLY RELATED TO EMPLOYMENT.

24 (iv) VOCATIONAL TRAINING DIRECTLY RELATED TO EMPLOYMENT.

25 (v) UNPAID WORKFORCE ENGAGEMENT DIRECTLY RELATED TO
26 EMPLOYMENT, INCLUDING, BUT NOT LIMITED TO, AN INTERNSHIP.

27 (vi) TRIBAL EMPLOYMENT PROGRAMS.

1 (vii) PARTICIPATION IN SUBSTANCE USE DISORDER TREATMENT.

2 (viii) COMMUNITY SERVICE.

3 (ix) JOB SEARCH DIRECTLY RELATED TO JOB TRAINING.

4 (H) "RECIPIENT" MEANS AN INDIVIDUAL RECEIVING MEDICAL
5 ASSISTANCE UNDER THIS ACT.

6 (I) "SUBSTANCE USE DISORDER" MEANS THAT TERM AS DEFINED IN
7 SECTION 100D OF THE MENTAL HEALTH CODE, 1974 PA 258, MCL 330.1100D.

8 (J) "UNEMPLOYMENT BENEFITS" MEANS BENEFITS RECEIVED UNDER THE
9 MICHIGAN EMPLOYMENT SECURITY ACT, 1936 (EX SESS) PA 1, MCL 421.1 TO
10 421.75.

11 SEC. 107B. (1) NO LATER THAN OCTOBER 1, 2018, THE DEPARTMENT
12 MUST APPLY FOR OR APPLY TO AMEND A WAIVER UNDER SECTION 1115 OF THE
13 SOCIAL SECURITY ACT, 42 USC 1315, AND SUBMIT SUBSEQUENT WAIVERS TO
14 PROHIBIT AND PREVENT A LAPSE IN THE WORKFORCE ENGAGEMENT
15 REQUIREMENTS AS A CONDITION OF RECEIVING MEDICAL ASSISTANCE UNDER
16 SECTION 105D. THE WAIVER MUST BE A REQUEST TO ALLOW FOR ALL OF THE
17 FOLLOWING:

18 (A) A REQUIREMENT OF 80 HOURS AVERAGE PER MONTH OF QUALIFYING
19 ACTIVITIES OR A COMBINATION OF ANY QUALIFYING ACTIVITIES, TO COUNT
20 TOWARD THE WORKFORCE ENGAGEMENT REQUIREMENT UNDER THIS SECTION.

21 (B) A REQUIREMENT THAT ABLE-BODIED RECIPIENTS VERIFY THAT THEY
22 ARE MEETING THE WORKFORCE ENGAGEMENT REQUIREMENTS BY THE TENTH OF
23 EACH MONTH FOR THE PREVIOUS MONTH'S QUALIFYING ACTIVITIES THROUGH
24 MIBRIDGES OR ANY OTHER SUBSEQUENT SYSTEM. A RECIPIENT IS ALLOWED 3
25 MONTHS OF NONCOMPLIANCE WITHIN A 12-MONTH PERIOD. THE RECIPIENT MAY
26 USE A NONCOMPLIANCE MONTH EITHER BY SELF-REPORTING THAT HE OR SHE
27 IS NOT IN COMPLIANCE THAT MONTH OR BY THE DEFAULT METHOD OF NOT

1 REPORTING COMPLIANCE FOR THAT MONTH. THE DEPARTMENT SHALL NOTIFY
2 THE RECIPIENT AFTER EACH TIME A NONCOMPLIANCE MONTH IS USED. AFTER
3 A RECIPIENT USES 3 NONCOMPLIANCE MONTHS IN A 12-MONTH PERIOD, THE
4 RECIPIENT LOSES COVERAGE FOR AT LEAST 1 MONTH UNTIL HE OR SHE
5 BECOMES COMPLIANT UNDER THIS SECTION.

6 (C) ALLOW SUBSTANCE USE DISORDER TREATMENT THAT IS COURT-
7 ORDERED, PRESCRIBED BY A LICENSED MEDICAL PROFESSIONAL, OR IS A
8 MEDICAID-FUNDED SUBSTANCE USE DISORDER TREATMENT, TO COUNT TOWARD
9 THE WORKFORCE ENGAGEMENT REQUIREMENTS IF THE TREATMENT IMPEDES THE
10 ABILITY TO MEET THE WORKFORCE ENGAGEMENT REQUIREMENTS.

11 (D) A REQUIREMENT THAT COMMUNITY SERVICE MUST BE COMPLETED
12 WITH A NONPROFIT ORGANIZATION THAT IS EXEMPT FROM TAXATION UNDER
13 SECTION 501(C) (3) OR 501(C) (4) OF THE INTERNAL REVENUE CODE OF
14 1986, 26 USC 501. COMMUNITY SERVICE CAN ONLY BE USED AS A
15 QUALIFYING ACTIVITY FOR UP TO 3 MONTHS IN A 12-MONTH PERIOD.

16 (E) A REQUIREMENT THAT A RECIPIENT WHO IS ALSO A RECIPIENT OF
17 THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM OR THE TEMPORARY
18 ASSISTANCE FOR NEEDY FAMILIES PROGRAM WHO IS IN COMPLIANCE WITH OR
19 EXEMPT FROM THE WORK REQUIREMENTS OF THE SUPPLEMENTAL NUTRITION
20 ASSISTANCE PROGRAM OR THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
21 PROGRAM IS CONSIDERED TO BE IN COMPLIANCE WITH OR EXEMPT FROM THE
22 WORKFORCE ENGAGEMENT REQUIREMENTS IN THIS SECTION.

23 (F) AN EXEMPTION FOR A RECIPIENT WHO MEETS 1 OR MORE OF THE
24 FOLLOWING CONDITIONS:

25 (i) A RECIPIENT WHO IS THE CARETAKER OF A FAMILY MEMBER WHO IS
26 UNDER THE AGE OF 6 YEARS. THIS EXEMPTION ALLOWS ONLY 1 PARENT AT A
27 TIME TO BE A CARETAKER, NO MATTER HOW MANY CHILDREN ARE BEING CARED

1 FOR.

2 (ii) A RECIPIENT WHO IS CURRENTLY RECEIVING TEMPORARY OR
3 PERMANENT LONG-TERM DISABILITY BENEFITS FROM A PRIVATE INSURER OR
4 FROM THE GOVERNMENT.

5 (iii) A RECIPIENT WHO IS A FULL-TIME STUDENT WHO IS NOT A
6 DEPENDENT OF A PARENT OR GUARDIAN OR WHOSE PARENT OR GUARDIAN
7 QUALIFIES FOR MEDICAID. THIS SUBPARAGRAPH INCLUDES A STUDENT IN A
8 POSTSECONDARY INSTITUTION OR CERTIFICATE PROGRAM.

9 (iv) A RECIPIENT WHO IS PREGNANT.

10 (v) A RECIPIENT WHO IS THE CARETAKER OF A DEPENDENT WITH A
11 DISABILITY WHICH DEPENDENT NEEDS FULL-TIME CARE BASED ON A LICENSED
12 MEDICAL PROFESSIONAL'S ORDER. THIS EXEMPTION IS ALLOWED 1 TIME PER
13 HOUSEHOLD.

14 (vi) A RECIPIENT WHO IS THE CARETAKER OF AN INCAPACITATED
15 INDIVIDUAL EVEN IF THE INCAPACITATED INDIVIDUAL IS NOT A DEPENDENT
16 OF THE CARETAKER.

17 (vii) A RECIPIENT WHO HAS PROVEN THAT HE OR SHE HAS MET THE
18 GOOD CAUSE TEMPORARY EXEMPTION.

19 (viii) A RECIPIENT WHO HAS BEEN DESIGNATED AS MEDICALLY FRAIL.

20 (ix) A RECIPIENT WHO HAS A MEDICAL CONDITION THAT RESULTS IN A
21 WORK LIMITATION ACCORDING TO A LICENSED MEDICAL PROFESSIONAL'S
22 ORDER.

23 (x) A RECIPIENT WHO HAS BEEN INCARCERATED WITHIN THE LAST 6
24 MONTHS.

25 (xi) A RECIPIENT WHO IS RECEIVING UNEMPLOYMENT BENEFITS FROM
26 THIS STATE. THIS EXEMPTION APPLIES DURING THE PERIOD THE RECIPIENT
27 RECEIVED UNEMPLOYMENT BENEFITS AND ENDS WHEN THE RECIPIENT IS NO

1 LONGER RECEIVING UNEMPLOYMENT BENEFITS.

2 (xii) A RECIPIENT WHO IS UNDER 21 YEARS OF AGE WHO HAD
3 PREVIOUSLY BEEN IN A FOSTER CARE PLACEMENT IN THIS STATE.

4 (2) AFTER THE WAIVER REQUESTED UNDER THIS SECTION IS APPROVED,
5 THE DEPARTMENT MUST INCLUDE, BUT IS NOT LIMITED TO, ALL OF THE
6 FOLLOWING, AS APPROVED IN THE WAIVER, IN ITS IMPLEMENTATION OF THE
7 WORKFORCE ENGAGEMENT REQUIREMENTS UNDER THIS SECTION:

8 (A) A REQUIREMENT OF 80 HOURS AVERAGE PER MONTH OF QUALIFYING
9 ACTIVITIES OR A COMBINATION OF ANY QUALIFYING ACTIVITIES COUNTS
10 TOWARD THE WORKFORCE ENGAGEMENT REQUIREMENT UNDER THIS SECTION.

11 (B) A REQUIREMENT THAT ABLE-BODIED RECIPIENTS MUST VERIFY THAT
12 THEY ARE MEETING THE WORKFORCE ENGAGEMENT REQUIREMENTS BY THE TENTH
13 OF EACH MONTH FOR THE PREVIOUS MONTH'S QUALIFYING ACTIVITIES
14 THROUGH MIBRIDGES OR ANY OTHER SUBSEQUENT SYSTEM. A RECIPIENT IS
15 ALLOWED 3 MONTHS OF NONCOMPLIANCE WITHIN A 12-MONTH PERIOD. THE
16 RECIPIENT MAY USE A NONCOMPLIANCE MONTH EITHER BY SELF-REPORTING
17 THAT HE OR SHE IS NOT IN COMPLIANCE THAT MONTH OR BY THE DEFAULT
18 METHOD OF NOT REPORTING COMPLIANCE FOR THAT MONTH. THE DEPARTMENT
19 SHALL NOTIFY THE RECIPIENT AFTER EACH TIME A NONCOMPLIANCE MONTH IS
20 USED. AFTER A RECIPIENT USES 3 NONCOMPLIANCE MONTHS IN A 12-MONTH
21 PERIOD, THE RECIPIENT LOSES COVERAGE FOR AT LEAST 1 MONTH UNTIL HE
22 OR SHE BECOMES COMPLIANT UNDER THIS SECTION.

23 (C) ALLOWING SUBSTANCE USE DISORDER TREATMENT THAT IS COURT-
24 ORDERED, IS PRESCRIBED BY A LICENSED MEDICAL PROFESSIONAL, OR IS A
25 MEDICAID-FUNDED SUBSTANCE USE DISORDER TREATMENT, TO COUNT TOWARD
26 THE WORKFORCE ENGAGEMENT REQUIREMENTS IF THE TREATMENT IMPEDES THE
27 ABILITY TO MEET THE WORKFORCE ENGAGEMENT REQUIREMENTS.

1 (D) A REQUIREMENT THAT COMMUNITY SERVICE MUST BE COMPLETED
2 WITH A NONPROFIT ORGANIZATION THAT IS EXEMPT FROM TAXATION UNDER
3 SECTION 501(C) (3) OR 501(C) (4) OF THE INTERNAL REVENUE CODE OF
4 1986, 26 USC 501. COMMUNITY SERVICE CAN ONLY BE USED AS A
5 QUALIFYING ACTIVITY FOR UP TO 3 MONTHS IN A 12-MONTH PERIOD.

6 (E) A REQUIREMENT THAT A RECIPIENT WHO IS ALSO A RECIPIENT OF
7 THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM OR THE TEMPORARY
8 ASSISTANCE FOR NEEDY FAMILIES PROGRAM WHO IS IN COMPLIANCE WITH OR
9 EXEMPT FROM THE WORK REQUIREMENTS OF THE SUPPLEMENTAL NUTRITION
10 ASSISTANCE PROGRAM OR THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
11 PROGRAM IS CONSIDERED TO BE IN COMPLIANCE WITH OR EXEMPT FROM THE
12 WORKFORCE ENGAGEMENT REQUIREMENTS IN THIS SECTION.

13 (F) AN EXEMPTION FOR A RECIPIENT WHO MEETS 1 OR MORE OF THE
14 FOLLOWING CONDITIONS:

15 (i) A RECIPIENT WHO IS THE CARETAKER OF A FAMILY MEMBER WHO IS
16 UNDER THE AGE OF 6 YEARS. THIS EXEMPTION ALLOWS ONLY 1 PARENT AT A
17 TIME TO BE A CARETAKER, NO MATTER HOW MANY CHILDREN ARE BEING CARED
18 FOR.

19 (ii) A RECIPIENT WHO IS CURRENTLY RECEIVING TEMPORARY OR
20 PERMANENT LONG-TERM DISABILITY BENEFITS FROM A PRIVATE INSURER OR
21 FROM THE GOVERNMENT.

22 (iii) A RECIPIENT WHO IS A FULL-TIME STUDENT WHO IS NOT A
23 DEPENDENT OF A PARENT OR GUARDIAN OR WHOSE PARENT OR GUARDIAN
24 QUALIFIES FOR MEDICAID. THIS SUBPARAGRAPH INCLUDES A STUDENT IN A
25 POSTSECONDARY INSTITUTION OR A CERTIFICATE PROGRAM.

26 (iv) A RECIPIENT WHO IS PREGNANT.

27 (v) A RECIPIENT WHO IS THE CARETAKER OF A DEPENDENT WITH A

1 DISABILITY WHICH DEPENDENT NEEDS FULL-TIME CARE BASED ON A LICENSED
2 MEDICAL PROFESSIONAL'S ORDER. THIS EXEMPTION IS ALLOWED 1 TIME PER
3 HOUSEHOLD.

4 (vi) A RECIPIENT WHO IS THE CARETAKER OF AN INCAPACITATED
5 INDIVIDUAL EVEN IF THE INCAPACITATED INDIVIDUAL IS NOT A DEPENDENT
6 OF THE CARETAKER.

7 (vii) A RECIPIENT WHO HAS PROVEN THAT HE OR SHE HAS MET THE
8 GOOD CAUSE TEMPORARY EXEMPTION.

9 (viii) A RECIPIENT WHO HAS BEEN DESIGNATED AS MEDICALLY FRAIL.

10 (ix) A RECIPIENT WHO HAS A MEDICAL CONDITION THAT RESULTS IN A
11 WORK LIMITATION ACCORDING TO A LICENSED MEDICAL PROFESSIONAL'S
12 ORDER.

13 (x) A RECIPIENT WHO HAS BEEN INCARCERATED WITHIN THE LAST 6
14 MONTHS.

15 (xi) A RECIPIENT WHO IS RECEIVING UNEMPLOYMENT BENEFITS FROM
16 THIS STATE. THIS EXEMPTION APPLIES DURING THE PERIOD THE RECIPIENT
17 RECEIVED UNEMPLOYMENT BENEFITS AND ENDS WHEN THE RECIPIENT IS NO
18 LONGER RECEIVING UNEMPLOYMENT BENEFITS.

19 (xii) A RECIPIENT WHO IS UNDER 21 YEARS OF AGE WHO HAD
20 PREVIOUSLY BEEN IN A FOSTER CARE PLACEMENT IN THIS STATE.

21 (3) THE DEPARTMENT MAY FIRST DIRECT RECIPIENTS TO EXISTING
22 RESOURCES FOR JOB TRAINING OR OTHER EMPLOYMENT SERVICES, CHILD CARE
23 ASSISTANCE, TRANSPORTATION, OR OTHER SUPPORTS. THE DEPARTMENT MAY
24 DEVELOP STRATEGIES FOR ASSISTING RECIPIENTS TO MEET WORKFORCE
25 ENGAGEMENT REQUIREMENTS UNDER THIS SECTION.

26 (4) BEGINNING OCTOBER 1, 2018 AND EACH YEAR THE DEPARTMENT
27 SUBMITS A WAIVER TO PROHIBIT AND PREVENT A LAPSE IN THE WORKFORCE

1 ENGAGEMENT REQUIREMENTS AFTER THAT, THE MEDICAID DIRECTOR MUST
2 SUBMIT TO THE GOVERNOR, THE SENATE MAJORITY LEADER, AND THE SPEAKER
3 OF THE HOUSE OF REPRESENTATIVES A LETTER CONFIRMING THE SUBMISSION
4 OF THE WAIVER REQUEST REQUIRED UNDER SUBSECTION (1).

5 (5) BEGINNING JANUARY 1, 2020, THE DEPARTMENT MUST EXECUTE A
6 SURVEY TO OBTAIN THE INFORMATION NEEDED TO COMPLETE AN EVALUATION
7 OF THE MEDICAL ASSISTANCE PROGRAM UNDER SECTION 105D TO DETERMINE
8 HOW MANY RECIPIENTS HAVE LEFT THE HEALTHY MICHIGAN PROGRAM AS A
9 RESULT OF OBTAINING EMPLOYMENT AND MEDICAL BENEFITS.

10 (6) THE DEPARTMENT MUST EXECUTE A SURVEY TO OBTAIN THE
11 INFORMATION NEEDED TO SUBMIT A REPORT TO THE LEGISLATURE BEGINNING
12 JANUARY 1, 2021, AND EVERY JANUARY 1 AFTER THAT, THAT SHOWS, FOR
13 MEDICAL ASSISTANCE UNDER SECTION 105D KNOWN AS HEALTHY MICHIGAN,
14 THE NUMBER OF EXEMPTIONS FROM WORKFORCE ENGAGEMENT REQUIREMENTS
15 GRANTED TO INDIVIDUALS IN THAT YEAR AND THE REASON THE EXEMPTIONS
16 WERE GRANTED.

17 (7) THE DEPARTMENT SHALL ENFORCE THE PROVISIONS OF THIS
18 SECTION BY CONDUCTING THE COMPLIANCE REVIEW PROCESS ON MEDICAL
19 ASSISTANCE RECIPIENTS UNDER SECTION 105D WHO ARE REQUIRED TO MEET
20 THE WORKFORCE ENGAGEMENT REQUIREMENTS OF THIS SECTION. IF A
21 RECIPIENT IS FOUND, THROUGH THE COMPLIANCE REVIEW PROCESS, TO HAVE
22 MISREPRESENTED HIS OR HER COMPLIANCE WITH THE WORKFORCE ENGAGEMENT
23 REQUIREMENTS IN THIS SECTION, HE OR SHE SHALL NOT BE ALLOWED TO
24 PARTICIPATE IN THE HEALTHY MICHIGAN PROGRAM UNDER SECTION 105D FOR
25 A 1-YEAR PERIOD.

26 (8) THE DEPARTMENT SHALL IMPLEMENT THE REQUIREMENTS OF THIS
27 SECTION NO LATER THAN JANUARY 1, 2020, AND SHALL NOTIFY RECIPIENTS

1 TO WHOM THE WORKFORCE ENGAGEMENT REQUIREMENTS DESCRIBED IN THIS
2 SECTION ARE LIKELY TO APPLY OF THE WORKFORCE ENGAGEMENT
3 REQUIREMENTS 90 DAYS IN ADVANCE.

4 (9) THE COST OF INITIAL IMPLEMENTATION OF THE WORKFORCE
5 ENGAGEMENT REQUIREMENTS REQUIRED UNDER THIS SECTION SHALL NOT BE
6 CONSIDERED WHEN DETERMINING THE COST-BENEFIT ANALYSIS REQUIRED
7 UNDER SECTION 105D(28)(B). THE COST OF INITIAL IMPLEMENTATION DOES
8 NOT INCLUDE THE COST OF ONGOING ADMINISTRATION OF THE WORKFORCE
9 ENGAGEMENT REQUIREMENTS. THE ONGOING COSTS OF ADMINISTERING THE
10 WORKFORCE ENGAGEMENT REQUIREMENTS REQUIRED UNDER THIS SECTION MAY
11 HAVE UP TO A \$5,000,000.00 GENERAL FUND/GENERAL PURPOSE REVENUE
12 LIMIT THAT SHALL NOT BE COUNTED WHEN DETERMINING THE COST-BENEFIT
13 ANALYSIS REQUIRED UNDER SECTION 105D(28)(B). ANY ONGOING COSTS
14 ABOVE \$5,000,000.00 OF GENERAL FUND/GENERAL PURPOSE REVENUE TO
15 ADMINISTER THE WORKFORCE ENGAGEMENT REQUIREMENTS UNDER THIS SECTION
16 SHALL BE CONSIDERED IN THE COST-BENEFIT ANALYSIS REQUIRED UNDER
17 SECTION 105D(28)(B).

18 (10) BEGINNING JANUARY 1, 2020, MEDICAL ASSISTANCE RECIPIENTS
19 WHO ARE NOT EXEMPT FROM THE WORKFORCE ENGAGEMENT REQUIREMENTS UNDER
20 THIS SECTION MUST BE IN COMPLIANCE WITH THIS SECTION. BEGINNING
21 JANUARY 1, 2020, A MEDICAL ASSISTANCE APPLICANT WHO IS NOT EXEMPT
22 FROM THE WORK ENGAGEMENT REQUIREMENTS UNDER THIS SECTION MUST BE IN
23 COMPLIANCE WITH THIS SECTION NOT MORE THAN 30 DAYS AFTER AN
24 ELIGIBILITY DETERMINATION IS MADE.

25 (11) THE DEPARTMENT SHALL NOT WITHDRAW, TERMINATE, OR AMEND
26 ANY WAIVER SUBMITTED UNDER THIS SECTION WITHOUT THE EXPRESS
27 APPROVAL OF THE LEGISLATURE IN THE FORM OF A BILL ENACTED BY LAW.

1 Enacting section 1. This amendatory act takes effect 90 days
2 after the date it is enacted into law.