THE SOCIAL WELFARE ACT
Act 280 of 1939

AN ACT to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1950, Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1965, Act 283, Imd. Eff. July 22, 1965;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1967, Act 58, Imd. Eff. June 20, 1967;—Am. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1987, Act 184, Imd. Eff. Nov. 30, 1987;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

The People of the State of Michigan enact:

STATE DEPARTMENT OF SOCIAL SERVICES

400.1 Family independence agency; creation; powers and duties; director, assistants, and employees; rules; successor to juvenile institute commission; other references.

Sec. 1. (1) A department of state government is created that shall be known and designated as the family independence agency, and that shall possess the powers granted and perform the duties imposed in this act. The family independence agency shall consist of a director and the assistants and employees appointed or employed in the family independence agency.

(2) The family independence agency is responsible for the operation and supervision of the institutions and facilities established within the family independence agency. The institutions and facilities may be operated on a coeducational basis. The family independence agency shall make and enforce its own rules, not inconsistent with the law governing the institutions or facilities under its control, respecting the conduct of the institutions and facilities, discipline in the institutions and facilities, the care of property, and the welfare of the residents.

(3) The family independence agency shall be, in all respects, the legal successor to the powers, duties and responsibilities of the juvenile institute commission.

(4) A reference in this act to "the state department of social services", "the state department", or "department" means the family independence agency.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1943, Act 208, Imd. Eff. Apr. 17, 1943;—Am. 1947, Act 224, Imd. Eff. June 17, 1947;—CL 1948, 400.1;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1972, Act 301, Eff. Jan. 1, 1973;—Am. 1995, Act 223, Eff. Mar. 28, 1996.

Compiler's note: For transfer of powers and duties of the medical services administration, medical assistance program and state medical program from the department of social services, or the director, to the department of community health, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of adult foster care licensing, adult foster care licensing advisory council, and child welfare licensing from the department of social services to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For renaming family independence agency to department of human services, see E.R.O. No. 2004-4, compiled at MCL 400.226.

For transfer of powers and duties of the bureau of family services from the department of consumer and industry services to the family independence agency by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

For transfer of powers and duties of adult foster care licensing advisory council to the family independence agency by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

For transfer of powers and duties of adult foster care licensing advisory council from department of human services and director of department of human services to the director of department of licensing and regulatory affairs, see E.R.O. No. 2015-1, compiled at MCL 400.227.

For creation of department of health and human services and abolishment of department of human services, see E.R.O. No. 2015-1, compiled at MCL 400.227.

Transfer of powers: See MCL 16.552.

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Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.1a Social welfare act; short title.

Sec. 1a. This act shall be known and may be cited as "The social welfare act".

History: Add. 1943, Act 85, Eff. July 30, 1943;—CL 1948, 400.1a.

Compiler's note: For creation of department of health and human services and abolishment of department of human services, see E.R.O. No. 2015-1, compiled at MCL 400.227.

Popular name: Act 280

400.1b Annual appropriation act as time-limited addendum; inclusion of program not as entitlement.

Sec. 1b. (1) This act shall be read in conjunction with the annual appropriation act appropriating funds for the department for each fiscal year. The annual appropriation act shall be considered as a time-limited addendum to this act.

(2) A program created in or authorized under this act is subject to the annual appropriation of funds. The inclusion of a program in this act does not create an entitlement to that program, and any state department responsible for administering a program under this act is not required to operate that program unless the legislature appropriates funds for that program.

History: Add. 1969, Act 278, Imd. Eff. Aug. 11, 1969;—Am. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2010, Act 173, Imd. Eff. Sept. 30, 2010.

Popular name: Act 280

400.1c Compensation of certain employees injured during course of employment as result of assault by recipient of social services.

Sec. 1c. (1) A person employed by the department of social services at the W.J. Maxey campus in Whitmore lake or any of its affiliated facilities, at the Adrian training school in Adrian, the Arbor Heights center in Ann Arbor, Camp Nokomis in Prudenville, Camp Shawano in Grayling, or a similar facility under the jurisdiction of the department established or funded by the state after the effective date of this section, who is injured during the course of his or her employment as a result of an assault by a recipient of social services shall receive his or her full wages by the state department until worker's compensation benefits begin and then shall receive in addition to worker's compensation benefits a supplement from the state department which together with the worker's compensation benefits shall equal but not exceed the weekly net wage of the employee at the time of the injury. This supplement shall only apply while the person is on the state department's payroll and is receiving worker's compensation benefits and shall include an employee who is currently receiving worker's compensation due to an injury covered by this section. Fringe benefits normally received by an employee shall be in effect during the time the employee receives the supplement provided by this section from the department.

(2) Subsection (1) shall apply whether the employee was directly assaulted or was assaulted as a result of aiding another employee in subduing a recipient.

History: Add. 1978, Act 131, Imd. Eff. May 4, 1978.

Popular name: Act 280

400.2 Michigan social welfare commission; powers and duties; appointment, terms, and qualifications of members; governor as ex officio member; oath; removal; vacancies; conducting business at public meeting; notice; quorum; meetings; failure to attend meetings; designation of chairperson and vice-chairperson; compensation and expenses; availability of writings to public.

Sec. 2. (1) The administration of the powers and duties of the state department shall be vested in a commission of 5 members which commission shall be known as the Michigan social welfare commission. A member of the commission shall not be a member of another commission or board, or hold another position with a state institution or department. Members of the commission shall be appointed by the governor, by and with the advice and consent of the senate, for a term of 5 years each. Of the members first appointed, 1 shall be appointed for a term of 1 year, 1 for a term of 2 years, 1 for a term of 3 years, 1 for a term of 4 years, and 1 for a term of 5 years.

(2) Members of the commission shall be citizens and residents of this state for not less than 5 years who possess and have demonstrated sincere interest, knowledge, and ability consistent with the responsibilities of the office, and not more than 3 of whom shall be members of the same political party. The governor shall be

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an ex officio member of the commission. Each member of the commission shall qualify by taking and filing with the secretary of state the constitutional oath of office and shall hold office until the appointment and qualification of a successor. A member of the commission may be removed by the governor for misfeasance, malfeasance, or nonfeasance in office, after hearing. Vacancies in the membership of the commission shall be filled for the remainder of the unexpired term, in the same manner as the original appointment.

(3) The business which the commission may perform shall be conducted at a public meeting of the commission held in compliance with Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws. Public notice of the time, date, and place of the meeting shall be given in the manner required by Act No. 267 of the Public Acts of 1976. A majority of the members of the commission shall constitute a quorum for the transaction of business. The commission shall meet on the call of the chairperson, or on a written request to the chairperson signed by 3 members of the commission, or at times and places as are prescribed by the rules of the commission. The commission shall hold not less than 12 meetings each fiscal year, with an interval of not more than 1 month between meetings.

(4) The failure on the part of a member to attend 3 consecutive meetings of the commission, unless excused by a formal vote of the commission, shall be considered by the governor as ground for removal of the nonattending member, and upon removal, the governor may appoint a successor. The commission shall annually designate 1 member to act as chairperson and 1 member to act as vice-chairperson of the commission.

(5) Each member of the commission shall be reimbursed for necessary travel and other expenses, and shall be paid $15.00 per day when in actual session, to be paid in the same manner as expenses of other state officers are paid.

(6) Except as prescribed in sections 35 and 64, a writing prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function shall be made available to the public in compliance with Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.2;—Am. 1978, Act 224, Imd. Eff. June 13, 1978.

Transfer of powers: See MCL 16.553.

Popular name: Act 280

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400.3 Family independence agency; director; appointment; salary; expenses; intent as to references.

Sec. 3. (1) The director of the family independence agency shall be appointed by the governor with the advice and consent of the senate, and shall serve at the pleasure of the governor. The director shall be the executive officer of the family independence agency and shall be responsible to the governor for performing his or her duties.

(2) The director shall receive such salary as shall be appropriated by the legislature, and shall receive actual and necessary traveling and other expenses incurred in the discharge of his or her official duties, to be paid in the same manner as salaries and expenses of other state employees are paid.

(3) Whenever reference is made in this act to the "bureau of social security", or the "state bureau", reference shall be deemed to be intended to be made to the family independence agency.

(4) Whenever reference is made in this act to the "supervisor of the state bureau", reference shall be deemed to be made to the director of the family independence agency.

(5) For counties having a population of 600,000 or less and for all cities regardless of population, whenever reference is made in this act to the "county bureau of social aid", reference shall be deemed to be made to the county or city family independence agency.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 217, Eff. May 18, 1945;—CL 1948, 400.3;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1996, Act 483, Imd. Eff. Dec. 27, 1996.

Compiler's note: The office of director of the state department of social welfare, referred to in this section, was transferred to the department of social services by MCL 16.553.

For creation of department of health and human services and abolishment of department of human services, see E.R.O. No. 2015-1, compiled at MCL 400.227.

Transfer of powers: See MCL 16.553.

Popular name: Act 280

400.3a Advisory committee; establishment; appointment of members; recommendations from county social services boards and county social services association; advising on statutes and policies.

Sec. 3a. (1) There is established an advisory committee to the state department consisting of 10 members

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appointed by the Michigan county social services association in accordance with a plan adopted by a majority of the members of the association. The association shall receive recommendations from the county social service boards and annually prepare and submit recommendations to the director. The director shall receive and respond to recommendations from the association on matters including but not limited to:

(a) The preparation of annual budget recommendations for the department prior to submission to the governor.

(b) Priorities for social services components of the state social services plan prepared in compliance with Title XX of the federal social security act, Public Law 93-641, and subsequent amendments.

(c) Program and policy guidelines relating to the conduct of and eligibility standards for general public relief and burial.

(d) Development and implementation of complementary policies between the department and county social service boards to promote local initiative efforts in work incentive and employment skills training programs.

(e) Policies and procedures relating to medicaid, food stamps, aid to families of dependent children and child welfare programs.

(2) The association may periodically advise the director, the governor, and the legislature on statutes and policies relating to state and local social services.

History: Add. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1975, Act 237, Eff. Dec. 1, 1975.

Popular name: Act 280

400.4 Executive heads of state institutions; appointment; employees, salaries and expenses.

Sec. 4. The commission shall appoint the executive heads of all state institutions and facilities under the supervision of the state department, and such assistants and employees for them and the state department, and may incur such other expenses as may be necessary to carry out the provisions of this act. The executive head of each state institution under the supervision of the state department shall be responsible for the employment of all assistants and employees thereof. The compensation of all such assistants and employees, and the number thereof, shall be within the appropriations made therefor by the legislature. Such assistants and employees shall receive their actual and necessary traveling and other expenses incurred in the discharge of their official duties. All salaries and expenses shall be paid in the same manner as the salaries and expenses of other state employees are paid.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.4;—Am. 1957, Act 95, Eff. Sept. 27, 1957.

Popular name: Act 280

400.5 Divisions within state department of social welfare; creation, abolition.

Sec. 5. The commission is hereby authorized and empowered to create or abolish divisions within the state department for the economic and efficient administration of the work of such department, and to allocate and re-allocate their several functions and duties.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.5.

Popular name: Act 280

400.5a Adverse action against child placing agency prohibited; basis.

Sec. 5a. In accordance with section 23g of chapter X of the probate code of 1939, 1939 PA 288, MCL 710.23g, and sections 14e and 14f of 1973 PA 116, MCL 722.124e and 722.124f, the department shall not take an adverse action against a child placing agency on the basis that the child placing agency has declined or will decline to provide services that conflict with, or provide services under circumstances that conflict with, the child placing agency's sincerely held religious beliefs contained in a written policy, statement of faith, or other document adhered to by the child placing agency.

History: Add. 2015, Act 55, Eff. Sept. 9, 2015.

Compiler's note: Enacting section 1 of Act 55 of 2015 provides:

"Enacting section 1. It is the intent of the legislature to protect child placing agencies' free exercise of religion protected by the United States constitution and the state constitution of 1963. This amendatory act is not intended to limit or deny any person's right to adopt a child or participate in foster care."

400.6 Rules, regulations, and policies; appointment and duties of bipartisan task force of legislators; applicability of subsection (2) to enrolled medicaid providers.

Sec. 6. (1) The family independence agency may promulgate all rules necessary or desirable for the administration of programs under this act. Rules shall be promulgated under the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. Beginning 2 years after the effective date of subsection (2), if the Michigan supreme court rules that

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sections 45 and 46 of Act No. 306 of the Public Acts of 1969, being sections 24.245 and 24.246 of the Michigan Compiled Laws, are unconstitutional and a statute requiring legislative review of administrative rules is not enacted within 90 days after the Michigan supreme court ruling, this subsection does not apply.

(2) The family independence agency may develop regulations to implement the goals and principles of assistance programs created under this act, including all standards and policies related to applicants and recipients that are necessary or desirable to administer the programs. These regulations are effective and binding on all those affected by the assistance programs. Except for policies described in subsections (3) and (4), regulations described in this subsection, setting standards and policies necessary or desirable to administer the programs, are exempt until the expiration of 12 months after the effective date of this subsection from the rule promulgation requirements of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. Upon the expiration of 12 months after the effective date of this subsection, regulations described in this subsection are not effective and binding unless processed as emergency rules under section 48 of Act No. 306 of the Public Acts of 1969, being section 24.248 of the Michigan Compiled Laws, or promulgated in accordance with Act No. 306 of the Public Acts of 1969.

(3) The family independence agency may develop policies to establish income and asset limits, types of income and assets to be considered for eligibility, and payment standards for assistance programs administered under this act. Policies developed under this subsection are effective and binding on all those affected by the assistance programs. Policies described in this subsection are exempt from the rule promulgation requirements of Act No. 306 of the Public Acts of 1969. Not less than 30 days before policies developed under this subsection are implemented, they shall be submitted to the senate and house standing committees and appropriation subcommittees with oversight of human services.

(4) The family independence agency may develop policies to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds. Policies developed under this subsection are effective and binding on all those affected by the programs. Policies described in this subsection are exempt from the rule promulgation requirements of Act No. 306 of the Public Acts of 1969.

(5) All rules, regulations, and policies established by the family independence agency shall be in writing, shall be provided to the legislature, and shall be made available for inspection by any member of the public at all offices of the family independence agency during regular business hours.

(6) Until the expiration of 12 months after the effective date of this subsection, a bipartisan task force of legislators appointed in the same manner as members are appointed to standing committees of the legislature shall meet regularly with the family independence agency to review proposed policies and regulations for the family independence program. Meetings of the bipartisan task force are subject to the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

(7) Subsection (2) does not apply to standards and policies related to the providers of services which have a written contractual relationship or are an enrolled medicaid provider with the family independence agency.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.6;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1995, Act 223, Eff. Mar. 28, 1996.

Compiler's note: In separate opinions, the Michigan Supreme Court held that Section 45(8), (9), (10), and (12) and the second sentence of Section 46(1) ("An agency shall not file a rule ... until at least 10 days after the date of the certificate of approval by the committee or after the legislature adopts a concurrent resolution approving the rule.") of the Administrative Procedures Act of 1969, in providing for the Legislature's reservation of authority to approve or disapprove rules proposed by executive branch agencies, did not comply with the enactment and presentment requirements of Const 1963, Art 4, and violated the separation of powers provision of Const 1963, Art 3, and, therefore, were unconstitutional. These specified portions were declared to be severable with the remaining portions remaining effective. Blank v Department of Corrections, 462 Mich 103 (2000).

Popular name: Act 280

Administrative rules: R 400.1 et seq. and R 400.3151 et seq. of the Michigan Administrative Code.

400.7 Rules and regulations; publication, seal, certified copies as evidence; body corporate, powers.

Sec. 7. The commission may devise a seal, and the rules and regulations of the commission may be published over the seal of the commission. Copies of all records and papers in the office of the state department, certified by a duly authorized agent of the commission and authenticated by the seal of the commission, shall be evidence in all cases equally, and with the like effect, as the originals. The commission shall be a body corporate, and is hereby authorized to lease any lands under its jurisdiction and to do any other act or thing necessary in carrying out the provisions of this act.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.7.

Popular name: Act 280

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400.8 Witnesses; compelled attendance, oaths; jurisdiction of courts.

Sec. 8. Any member of the commission or the director may issue a subpoena requiring any person to appear and be examined with reference to any matter within the jurisdiction of the commission and within the scope of the inquiry or investigation being conducted by the said commission or director, and to produce any books, records or papers, pertinent to such inquiry. Any member of the commission, the director, or their duly authorized agents, may administer an oath to a witness in any pending matter. In case of disobedience of a subpoena, the commission or director may by petition invoke the aid of the circuit court of the county in which the witness resides, or the circuit court of the county in which the inquiry is being held, to require the attendance and testimony of witnesses and the production of books, papers and documents. Any such circuit court of the state, may, in case of contumacy or refusal to obey a subpoena, issue an order requiring such person to appear and to produce books, records, and papers if so ordered and give evidence touching the matter in question. Any failure to obey such order of the court may be punished by such court as a contempt thereof.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.8;—Am. 1957, Act 95, Eff. Sept. 27, 1957.

Popular name: Act 280

400.9 Rules for conduct of hearings; procedure; hearing authority; powers and duties; review; representation of department; compliance with Open Meetings Act.

Sec. 9. (1) Pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, the director shall promulgate rules for the conduct of hearings within the state department. The rules shall provide adequate procedure for a fair hearing of appeals and complaints, when requested in writing by the state department or by an applicant for or recipient of, or former recipient of, assistance or service, financed in whole or in part by state or federal funds. Hearings shall be conducted by agents designated by the director. The director may appoint a hearing authority to decide these cases. The hearing authority shall be vested with the powers and duties of the director to hold and decide hearings. The director may also upon his or her own motion review a decision of a county or district department with respect to the granting of assistance financed in whole or in part by state or federal funds, and may consider and pass upon an application for assistance that has not been acted upon by the county or district department within a reasonable time.

(2) Irrespective of funding source, the state department may be represented in any hearing held pursuant to subsection (1) by a duly authorized employee or agent of the state department.

(3) A hearing held pursuant to this section shall be held as prescribed in the open meetings act, Act No. 267 of the Public Acts of 1976, as amended, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.9;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1971, Act 193, Imd. Eff. Dec. 20, 1971;—Am. 1978, Act 224, Imd. Eff. June 13, 1978;—Am. 1982, Act 131, Imd. Eff. Apr. 20, 1982;—Am. 1993, Act 41, Imd. Eff. May 27, 1993.

Popular name: Act 280

Administrative rules: R 400.1 et seq.; R 400.3351; and R 400.3401 et seq. of the Michigan Administrative Code.

400.10 Administration of social security act and food stamp act; cooperation with federal, state, and local governments; reports; welfare and relief problems; plan for distribution and allotment of federal moneys; rules; agreements; assuring federal approval.

Sec. 10. The family independence agency is designated as the state agency to cooperate with the federal government in the administration of the social security act, chapter 531, 49 Stat. 620. The family independence agency may administer the food stamp act of 1977, Public Law 88-525, 7 U.S.C. 2011 to 2012 and 2013 to 2032, and any other law which the governor or the legislature of the state may designate. The family independence agency may cooperate with the proper departments or agencies of the federal government and with all other departments or agencies of the state and local governments, and supervise the administration by local governmental departments or agencies of any plans established by the state in cooperation with the federal government under these provisions and the rules promulgated pursuant thereto. The director shall make reports, in such form and containing such information, required under the social security act, and shall comply with the requirements made to assure the correctness and verification of the reports.

(2) The director, with the approval of the governor, may cooperate with the federal government, or any of its agencies or instrumentalities, in handling the welfare and relief problems and needs of the people of this state, to the extent authorized by the laws of this state.

(3) The director may adopt any plan required or desirable to participate in the distribution of federal

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moneys or the assistance of the federal government, and may accept on behalf of the state any allotment of federal moneys. The state treasurer may forward state moneys to the federal social security administration for federal administration of the state supplemental program of the social security act in accordance with an agreement pertaining thereto. The director may promulgate rules and the director or his or her designee may enter into any agreement or agreements with federal, state, or local units of government or private agencies necessary to enable the state or such units to participate in any plan the director deems desirable for the welfare of the people of this state.

(4) For the purpose of assuring full federal approval of the activities of the department and local departments with respect to the operation of a plan, the director may do all things reasonable and proper to conform with federal requirements pertaining to methods and standards of administration. In making rules with respect thereto, there shall be included such methods and standards of administration for the conduct of the work of local units, including the necessary supervision thereof, as may be required for the receipt of aid from the federal government.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.10;—Am. 1950, Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1973, Act 156, Imd. Eff. Dec. 6, 1973;—Am. 1973, Act 189, Imd. Eff. Jan. 8, 1974;—Am. 1996, Act 483, Imd. Eff. Dec. 27, 1996.

Popular name: Act 280

Administrative rules: R 400.1 et seq.; R 400.1101 et seq.; R 400.7171 et seq.; R 400.7391 et seq.; and R 400.7701 et seq. of the Michigan Administrative Code.

400.10a Disclosure of certain recipients to law enforcement agency; federal approval; definitions.

Sec. 10a. (1) Notwithstanding any other provision of this act, and subject to subsection (2), the department shall disclose the address of a recipient, applicant, or known member of a recipient's or applicant's household to a federal, state, or local law enforcement officer if the officer furnishes the department with the name of the recipient, applicant, or known member of the recipient's or applicant's household, the recipient's, applicant's, or member's social security number or other identifying information, if known, and information showing that the recipient, applicant, or member of the household is subject to arrest under an outstanding warrant arising from a felony charge or under an outstanding warrant for extradition arising from a criminal charge in another jurisdiction, or is a material witness in a criminal case arising from a felony charge.

(2) If federal approval is required in order to prevent the loss of federal reimbursement as a result of the application of this section to a recipient receiving family independence assistance or food stamps, the department shall promptly take any action necessary to obtain federal approval. In the absence of any necessary federal approval, the department shall apply this section only to recipients of state family assistance and state disability assistance.

(3) As used in this section, section 10b, and section 10c:

(a) "Felony" means a violation of a penal law of this state or the United States for which the offender may be punished by imprisonment for more than 1 year, an offense expressly designated by law to be a felony, or a violation of felony probation or parole.

(b) "Known member of a recipient's household" means an individual listed on the recipient's application for public assistance as an individual who is living with the recipient.

(c) "Material witness" means an individual who is required by subpoena, summons, certificate, or other order of a court to appear and give testimony in a criminal case.

(d) "Public assistance" means family independence program, state family assistance, state disability assistance, food assistance program, or child development and care program provided under this act.

(e) "Recipient" means an individual receiving public assistance.

History: Add. 1996, Act 190, Eff. Oct. 1, 1996;—Am. 2011, Act 198, Imd. Eff. Oct. 18, 2011.

Popular name: Act 280

400.10b Individual subject to felony charge; eligibility for cash or food assistance; federal approval; review by department director; definitions.

Sec. 10b. (1) Subject to subsection (3) and except as provided in subsection (5), the department shall not grant cash assistance under this act to an individual if the department receives information provided under section 10a that the individual is subject to arrest under an outstanding warrant arising from a felony charge against that individual in this or any other jurisdiction. The department shall not grant food assistance to an individual if the individual has an outstanding felony warrant and law enforcement is actively seeking the individual. This subsection does not affect the eligibility for assistance of other members of the individual's household. An individual described in this subsection is eligible for cash assistance when he or she is no longer subject to arrest under an outstanding warrant as described in this section and law enforcement is not

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actively seeking the individual.

(2) Subject to subsection (3), the department shall not grant cash assistance under this act to an individual if the department receives information under section 84 of the corrections code of 1953, 1953 PA 232, MCL 791.284, that the individual has absconded from supervision under that act. Subject to subsection (3), the department shall not grant food assistance under this act to an individual if the department receives information under section 84 of the corrections code of 1953, 1953 PA 232, MCL 791.284, that the individual has absconded from supervision under that act and that law enforcement or the department of corrections is actively seeking the individual.

(3) If federal approval is required in order to prevent the loss of federal reimbursement as a result of the application of this section to a recipient receiving family independence program assistance or food assistance, the department shall promptly take any action necessary to obtain federal approval. In the absence of any necessary federal approval, the department shall apply this section only to recipients of state family assistance and state disability assistance.

(4) The department director or his or her designee shall review information provided by the department of state police under section 4 of the C.J.I.S. policy council act, 1974 PA 163, MCL 28.214, to determine if cash assistance or food assistance recipients or applicants are subject to arrest under an outstanding warrant as described in section 10a. The department director or his or her designee shall review information provided by the department of corrections under section 84 of the corrections code of 1953, 1953 PA 232, MCL 791.284, to determine if cash assistance recipients or applicants are subject to a warrant for absconding. The department director or his or her designee shall review information provided by the department of corrections under section 84 of the corrections code of 1953, 1953 PA 232, MCL 791.284, to determine if food assistance recipients or applicants are subject to a warrant for absconding and if law enforcement is actively seeking the recipients or applicants.

(5) Subject to subsection (3) and except as provided in subsection (1), the department shall not grant cash assistance or food assistance under this act to an individual if the department receives information from the department of state police as provided in subsection (4) that the individual is subject to an arrest under an outstanding warrant described in section 10a. Subject to subsection (3), the department shall not grant cash assistance under this act to an individual if the department receives information from the department of corrections that the individual has absconded from supervision. Subject to subsection (3), the department shall not grant food assistance under this act to an individual if the department receives information from the department of corrections that the individual has absconded from supervision and law enforcement is actively seeking the individual.

(6) As used in this section:

(a) "Abscond" and "actively seeking" mean those terms as defined in section 84 of the corrections code of 1953, 1953 PA 232, MCL 791.284.

(b) "Cash assistance" means cash benefits provided under the family independence program, the refugee assistance program, or state disability assistance.

(c) "Food assistance" means the food benefits provided under the food assistance program administered under this act.

History: Add. 1996, Act 190, Eff. Oct. 1, 1996;—Am. 2011, Act 198, Imd. Eff. Oct. 18, 2011;—Am. 2017, Act 13, Eff. June 29, 2017.

Popular name: Act 280

400.10c Automated program; development and implementation; comparison of list of individuals receiving public assistance with information regarding outstanding felony or extradition warrants; access to address information; report; "extradition warrant" defined.

Sec. 10c. (1) The department of technology, management, and budget shall work with the department and the department of state police to develop and implement an automated program that does a comparison of the department's list of public assistance recipients, and of any other list maintained by the department of individuals receiving assistance under this act, with the information regarding an outstanding felony warrant or extradition warrant received by the department of state police. This comparison shall only include public assistance recipients. Unless otherwise prohibited by law, this comparison shall include information regarding outstanding felony warrants or extradition warrants contained in a nonpublic record. The department of state police shall take all reasonable and necessary measures using the available technology to ensure the accuracy of information regarding outstanding felony warrants before transmitting the information under this subsection to the department. The department shall take all reasonable and necessary measures using the available technology to ensure the accuracy of this comparison before notifying a local office of an outstanding felony warrant or extradition warrant. If a comparison discloses that a person on the department's

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list of public assistance recipients has an outstanding felony warrant or extradition warrant or if the department is otherwise notified by the department of state police that a person has an outstanding felony warrant or extradition warrant, the department shall notify the local office handling the recipient's public assistance case of that outstanding felony warrant or extradition warrant. The local office shall take appropriate action regarding cases that local office receives notification of under this subsection.

(2) The department of technology, management, and budget shall work with the department and the department of state police to develop and implement an automated program that allows the department of state police to access address information of public assistance applicants or recipients. The department of technology, management, and budget shall ensure that the department of state police does not have access to benefit information, only address information.

(3) Not later than July 1, 2013, the automated program described in this section shall be implemented by the department. Upon implementation, the department shall submit a report to the chairpersons of the senate and house appropriations subcommittees handling the department budget, and the senate and house policy offices and fiscal agencies, that the automated program has been implemented.

(4) As used in this section, "extradition warrant" means an outstanding warrant for extradition arising from a criminal charge against the individual in another jurisdiction.

History: Add. 2011, Act 198, Imd. Eff. Oct. 18, 2011;—Am. 2012, Act 78, Imd. Eff. Apr. 11, 2012.

Popular name: Act 280

400.10d Determination of financial eligibility for family independence program or food assistance program; application of asset test.

Sec. 10d. For the purposes of determining financial eligibility for the family independence program or the food assistance program administered under this act, the department shall apply an asset test.

History: Add. 2012, Act 79, Imd. Eff. Apr. 11, 2012.

Popular name: Act 280

400.10e Determination of financial eligibility for family independence program and food assistance program; inclusion of money received from lottery or gambling winnings.

Sec. 10e. Money received from lottery winnings or other gambling winnings shall be included when determining financial eligibility for the family independence program and the food assistance program administered under this act as follows:

(a) If received as a lump-sum payment, lottery winnings and other gambling winnings shall be counted as assets.

(b) If received in installment payments, lottery winnings and other gambling winnings shall be counted as unearned income.

History: Add. 2012, Act 78, Imd. Eff. Apr. 11, 2012.

Popular name: Act 280

400.10e[1] Repealed. 2013, Act 41, Imd. Eff. June 5, 2013.

Compiler's note: The repealed section pertained to performance of incarceration match to determine eligibility for bridge card.

Popular name: Act 280

400.10f Performance of monthly incarceration match to determine eligibility for bridge card; issuance prohibited or terminated; performance of monthly match to determine if recipient is deceased.

Sec. 10f. (1) The department shall perform an incarceration match monthly to obtain information to assist in determining eligibility based on incarceration status.

(2) If the department determines that a recipient is incarcerated at the time the incarceration match is performed, the department shall not issue a bridge card to that incarcerated recipient. If a bridge card has already been issued to the incarcerated recipient, the department shall terminate that recipient's bridge card access.

(3) The department shall perform a monthly match using the United States social security death index database to determine if a recipient is deceased. If the department determines that a recipient is deceased at the time the United States social security death index match is performed, the department shall not issue a bridge card to that deceased recipient. If a bridge card has already been issued to the deceased recipient, the department shall terminate that recipient's bridge card access.

History: Add. 2013, Act 41, Imd. Eff. June 5, 2013.

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Popular name: Act 280

400.10g Determination of financial eligibility; money associated with designated beneficiary's ABLE savings account; "ABLE savings account", "designated beneficiary", and "qualified disability expenses" defined.

Sec. 10g. (1) For any assistance program for which financial eligibility is determined under this act, the department shall disregard in its financial eligibility determination money associated with a designated beneficiary's ABLE savings account, including, but not limited to, all of the following:

(a) Money in a designated beneficiary's ABLE savings account.

(b) Earnings on money in a designated beneficiary's ABLE savings account.

(c) Contributions to a designated beneficiary's own ABLE savings account.

(d) Distributions from an ABLE savings account for the designated beneficiary's qualified disability expenses.

(2) As used in this section, "ABLE savings account", "designated beneficiary", and "qualified disability expenses" mean those terms as defined in section 2 of the Michigan achieving a better life experience (ABLE) program act.

History: Add. 2015, Act 162, Eff. Jan. 26, 2016.

Popular name: Act 280

400.11 Definitions.

Sec. 11. As used in this section and sections 11a to 11f:

(a) “Abuse” means harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes, but is not limited to, nonaccidental physical or mental injury, sexual abuse, or maltreatment.

(b) “Adult in need of protective services” or “adult” means a vulnerable person not less than 18 years of age who is suspected of being or believed to be abused, neglected, or exploited.

(c) “Exploitation” means an action that involves the misuse of an adult's funds, property, or personal dignity by another person.

(d) “Neglect” means harm to an adult's health or welfare caused by the inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care. A person shall not be considered to be abused, neglected, or in need of emergency or protective services for the sole reason that the person is receiving or relying upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, and this act shall not require any medical care or treatment in contravention of the stated or implied objection of that person.

(e) “Protective services” includes, but is not limited to, remedial, social, legal, health, mental health, and referral services provided in response to a report of alleged harm or threatened harm because of abuse, neglect, or exploitation.

(f) “Vulnerable” means a condition in which an adult is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or because of advanced age.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983;—Am. 1990, Act 122, Imd. Eff. June 26, 1990.

Compiler's note: Former MCL 400.11, creating an irrevocable medical assistance account within the general fund, was repealed by Act 321 of 1966.

Popular name: Act 280

400.11a Reporting abuse, neglect, or exploitation of adult; oral report; contents of written report; reporting criminal activity; construction of section.

Sec. 11a. (1) A person who is employed, licensed, registered, or certified to provide health care, educational, social welfare, mental health, or other human services; an employee of an agency licensed to provide health care, educational, social welfare, mental health, or other human services; a law enforcement officer; or an employee of the office of the county medical examiner who suspects or has reasonable cause to believe that an adult has been abused, neglected, or exploited shall make immediately, by telephone or otherwise, an oral report to the county department of social services of the county in which the abuse, neglect, or exploitation is suspected of having or believed to have occurred. After making the oral report, the reporting person may file a written report with the county department. A person described in this subsection who is also required to make a report pursuant to section 21771 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being section 333.21771 of the Michigan Compiled Laws and who makes that report is not required to make a duplicate report to the county department of social services under this section.

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(2) A report made by a physician or other licensed health professional pursuant to subsection (1) shall not be considered a violation of any legally recognized privileged communication or a violation of article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws.

(3) In addition to those persons required to make an oral report under subsection (1), any person who suspects that an adult has been abused, neglected, or exploited may make a report to the county department of social services of the county in which the abuse, neglect, or exploitation is suspected of having occurred.

(4) A report made under this section shall contain the name of the adult and a description of the abuse, neglect, or exploitation. If possible, the report shall contain the adult's age and the names and addresses of the adult's guardian or next of kin, and of the persons with whom the adult resides, including their relationship to the adult. The report shall contain other information available to the reporting person that may establish the cause of the abuse, neglect, or exploitation and the manner in which the abuse, neglect, or exploitation occurred or is occurring. The county department shall reduce to writing the information provided in an oral report received pursuant to this section.

(5) The county department shall report to a police agency any criminal activity that it believes to be occurring, upon receipt of the oral report.

(6) This section shall not be construed as limiting the responsibilities of the police agency of a local unit of government to enforce the laws of this state or as precluding the police agency from reporting and investigating, as appropriate, alleged criminal conduct.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983;—Am. 1987, Act 208, Imd. Eff. Dec. 22, 1987;—Am. 1990, Act 122, Imd. Eff. June 26, 1990.

Popular name: Act 280

400.11b Investigation; purpose; basis; providing licensee with substance of allegations; response to allegations; cooperation of local law enforcement officers; investigation not to be in place of investigation of suspected criminal conduct; scope of investigation; in-person interview; search warrant; availability of protective services; collaboration with other agencies; petition for finding of incapacity and appointment of guardian or temporary guardian; petition for appointment of conservator; report; providing copy of report to state department and prosecuting attorney.

Sec. 11b. (1) Within 24 hours after receiving a report made or information obtained under section 11a, the county department shall commence an investigation to determine whether the person suspected of being or believed to be abused, neglected, or exploited is an adult in need of protective services. A reasonable belief on the part of the county department that the person is an adult in need of protective services is a sufficient basis for investigation. If an investigation pertains to an adult residing in an adult foster care facility licensed by the department of human services, the county department shall provide the adult foster care licensee with the substance of the abuse or neglect allegations as soon as practicable after the beginning of the investigation. The licensee shall have the opportunity to respond to the allegations, and the response shall be included in the record.

(2) Upon a request by the county department, local law enforcement officers shall cooperate with the county department in an investigation of suspected abuse, neglect, or exploitation. However, the investigation required by this section shall not be in place of an investigation by the appropriate police agency regarding suspected criminal conduct arising from the suspected abuse, neglect, or exploitation.

(3) The investigation shall include a determination of the nature, extent, and cause of the abuse, neglect, or exploitation; examination of evidence; identification, if possible, of the person responsible for the abuse, neglect, or exploitation; the names and conditions of other adults in the place of residence; an evaluation of the persons responsible for the care of the adult, if appropriate; the environment of the residence; the relationship of the adult to the person responsible for the adult's care; an evaluation as to whether or not the adult would consent to receiving protective services; and other pertinent data.

(4) The investigation shall include an in-person interview with the adult. The county department shall conduct the interview by means of a personal visit with the adult in the adult's dwelling or in the office of the county department. In attempting to conduct a personal visit with the adult in the adult's dwelling, if admission to the dwelling is denied, the county department may seek to obtain a search warrant as provided in 1966 PA 189, MCL 780.651 to 780.659.

(5) The investigation may include a medical, psychological, social, vocational, and educational evaluation and review.

(6) In the course of an investigation, the county department shall determine if the adult is or was abused,

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neglected, or exploited. The county department shall make available to the adult the appropriate and least restrictive protective services, directly or through the purchase of services from other agencies and professions, and shall take necessary action to safeguard and enhance the welfare of the adult, if possible. The county department also shall collaborate with law enforcement officers, courts of competent jurisdiction, and appropriate state and community agencies providing human services, which services are provided in relation to preventing, identifying, and treating adult abuse, neglect, or exploitation. If the abuse, neglect, or exploitation involves substance abuse, the county department shall collaborate with the local substance abuse coordinating agency as designated by the office of substance abuse services in the department of community health for a referral for substance abuse services. The county department may petition for a finding of incapacity and appointment of a guardian or temporary guardian as provided in section 5303 or 5312 of the estates and protected individuals code, 1998 PA 386, MCL 700.5303 and 700.5312, and may petition for the appointment of a conservator as provided in section 5401 of the estates and protected individuals code, 1998 PA 386, MCL 700.5401, for a vulnerable adult.

(7) Upon completion of an investigation, the county department shall prepare a written report of the investigation and its findings. A copy of this written report shall be forwarded to the department of human services upon the request of the department of human services.

(8) The county department may provide a copy of the written report to the prosecuting attorney for the county in which the adult suspected of being or believed to be abused, neglected, or exploited resides or is found.

(9) A representative from the department of human services, the department of state police, the department of attorney general, and the office of services to the aging, and an individual who is a representative of long-term care providers and is designated by the state attorney general, shall meet and develop a state model protocol for the investigation of vulnerable adult abuse cases. This state model protocol shall be developed not more than 1 year after the effective date of the amendatory act that added this subsection. A county prosecuting attorney, in cooperation with the local county department and local law enforcement agencies, may adopt a local protocol for the investigation of vulnerable adult abuse cases that is based on the state model protocol.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983;—Am. 1988, Act 422, Imd. Eff. Dec. 27, 1988;—Am. 1990, Act 122, Imd. Eff. June 26, 1990;—Am. 2000, Act 61, Eff. Apr. 1, 2000;—Am. 2012, Act 175, Imd. Eff. June 19, 2012.

Popular name: Act 280

400.11c Confidentiality of identity of person making report; immunity from civil liability; presumption; extent of immunity; abrogation of privileged communication; exception; sharing of information and records.

Sec. 11c. (1) The identity of a person making a report under section 11a or 11b shall be confidential, subject only to disclosure with the consent of that person or by judicial process. A person acting in good faith who makes a report or who assists in the implementation of sections 11 to 11f is immune from civil liability that might otherwise be incurred by making the report or by assisting in the making of the report. A person making a report or assisting in the implementation of sections 11 to 11f is presumed to have acted in good faith. The immunity from civil liability extends only to an act performed under sections 11 to 11f and does not extend to a negligent act that causes personal injury or death.

(2) Any legally recognized privileged communication, except that between attorney and client and except as specified in section 11a(2), is abrogated and does not constitute grounds for excusing a report otherwise required to be made under this act.

(3) Notwithstanding any other confidentiality provision in this act and sections 5 and 7(2) of the child protection law, 1975 PA 238, MCL 722.625 and 722.627, information or records in the possession of the department or the department of licensing and regulatory affairs may be shared to the extent necessary for the proper functioning of the department or the department of licensing and regulatory affairs in administering child or adult welfare or child or adult foster care facility licensing under this act or in an investigation conducted under section 43b. Information or records shared under this subsection shall not be released by the department or the department of licensing and regulatory affairs unless otherwise permitted under this act or other state or federal law.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983;—Am. 2016, Act 493, Eff. Apr. 6, 2017.

Popular name: Act 280

400.11d Availability of writing to public; correction of inaccurate statements; identification of unsubstantiated statements.

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Sec. 11d. (1) A writing prepared, owned, used, in the possession of, or retained by the state department in the performance of its duties under this act shall be made available to the public in compliance with Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(2) The state department shall correct any inaccurate statement and shall clearly identify any unsubstantiated statement in a record or report provided to the state department pursuant to sections 11 to 11e.

(3) Any person who is the subject of a report provided to the department pursuant to sections 11 to 11e may request that the director correct an inaccurate report or clearly identify as unsubstantiated any record of a case for which the investigation did not reveal an incident described in sections 11 to 11e. If the director determines that the request is valid, the state department shall take the appropriate action. However, a correction or identification provided for in this subsection shall not be made until an investigation has been completed and the case has been closed to receipt of adult protective services.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983.

Popular name: Act 280

400.11e Failure to make report; liability; disposition of fine.

Sec. 11e. (1) A person required to make a report pursuant to section 11a who fails to do so is liable civilly for the damages proximately caused by the failure to report, and a civil fine of not more than $500.00 for each failure to report.

(2) A civil fine which is ordered under subsection (1) shall be deposited in the general fund of the state, to be appropriated annually to the state department.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983.

Popular name: Act 280

400.11f Certain actions and investigations prohibited; report; interdepartmental agreements; coordinating investigations; agreement establishing criteria.

Sec. 11f. (1) The state department shall not take any action pursuant to sections 11 to 11e in the case of a person who is residing in a state funded and operated facility or institution, including but not limited to a correctional institution, mental hospital, psychiatric hospital, psychiatric unit, or a developmental disability regional center.

(2) The state department shall not investigate suspected abuse, neglect, or any other suspected incident pursuant to sections 11 to 11e if the department of public health has investigative and enforcement responsibility for the incident pursuant to section 20201, 21771, or 21799a of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.20201, 333.21771, and 333.21799a of the Michigan Compiled Laws. The state department shall refer a report of suspected abuse or neglect in an institution governed by those sections to the department of public health.

(3) Sections 11 to 11e do not preclude the director from entering into interdepartmental agreements to carry out the duties and responsibilities of the state department under sections 11 to 11e in state funded and operated facilities or institutions, or to coordinate investigation in state licensed facilities under contract with a state agency in order to avoid duplication of effort among state agencies having statutory responsibility to investigate.

(4) The state department and the department of attorney general shall enter into an agreement establishing criteria to be used to determine those complaints involving a facility that receives funding under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396d, 1396f to 1396g, and 1396i to 1396s, or involving the delivery of a service funded under title XIX of the social security act, which complaints shall be referred immediately to the department of attorney general for possible investigation and prosecution.

History: Add. 1982, Act 519, Eff. Mar. 30, 1983;—Am. 1990, Act 122, Imd. Eff. June 26, 1990.

Popular name: Act 280

400.12 Transfer of funds.

Sec. 12. All funds in the hands of the state treasurer or on deposit to the credit of any of the departments, boards, commissions and offices which are hereby abolished shall be transferred to and are hereby appropriated for the state department of social welfare, and shall be disbursed on its order.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.12.

Popular name: Act 280

400.13 Reciprocal agreements with other states; authorization, exception.

Sec. 13. The commission is hereby authorized, subject to the approval of the attorney general, to enter into

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reciprocal agreements with corresponding state agencies of other states, regarding the interstate transportation of indigent persons, and to arrange with the proper officials in this state for the acceptance, transfer and support of persons receiving any form of public aid or relief in other states in accordance with the terms of such reciprocal agreement: Provided, That this state shall not, nor shall any county or any county department of social welfare, in this state, be committed to the support of persons whom the commission determines are not entitled to public support under the laws of this state. This section shall be so interpreted and construed as to effectuate its general purpose to make uniform laws of such states as enact similar legislation.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.13.

Popular name: Act 280

400.14 Additional powers and duties of department; powers and duties of county social services boards as to general public relief transferred to department; changing eligibility standards and coverages for medical care.

Sec. 14. (1) The state department has all of the following additional powers and duties:

(a) To allocate and distribute to the county and district departments of social services, as provided in section 18, and in accordance with the rules promulgated by the director, money appropriated by the legislature or received from the federal government for the relief of destitution or unemployment within the state, or a political subdivision of the state.

(b) To distribute, as provided in this act, subject to federal rules and regulations, and in accordance with the rules promulgated by the director, money appropriated by the legislature or received from the federal government for the granting of aid to dependent children and supplemental security income; for medical, dental, optometric, nursing, pharmaceutical, and burial relief; for services furnished by professions under the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws; and for other relief or welfare services provided by law.

(c) To operate a day care program in rural and urban areas and assist in the development of sound programs and standards for day care by public organizations throughout the state. If the director, commissioner, or those officials responsible for enforcing a state or local building code determine that a dwelling unit fails to meet the standards of that code through fault of the landlord, the department may refuse to pay public assistance grants authorized under this act for payment of rent on the dwelling unit. A written notice of the refusal, stating the grounds for the refusal and listing the defects to be corrected, shall be mailed immediately to the landlord by certified mail. During the period of refusal, the landlord may bring an action against the department in the nature of quo warranto, but may not maintain an action for the rent or possession of the premises. If the defects have been corrected or if the department's refusal to pay is determined by a court of competent jurisdiction to be wrongful, the department shall pay the rent that is owed, but not more than the amount of the grants withheld.

(g) To assist other departments, agencies, and institutions of the federal and state governments, when so requested, in performing services in conformity with the purposes of this act. The director shall act as certifying agent for federal departments or agencies in determining eligibility of applicants for aid or service rendered by those departments or agencies. The rules of the state departments under this subsection shall be binding upon the county departments of social services.

(h) To collect and compile statistics, make special fact-finding studies, and publish reports in reference to the field of welfare, including a biennial report as provided in section 17.

(i) To arbitrate and decide disputed or contested claims between 2 or more counties relative to the settlement or domicile of a person or family given or in need of any form of public aid or relief, and to determine and declare the county of settlement or domicile in any instance when so requested or on the department's own volition. All decisions and determinations made under this subdivision shall be binding upon the county departments of social services.

(j) To administer or supervise relief or welfare functions vested in the department by law, and to provide for the progressive codification of the laws governing relief and welfare problems.

(k) To inspect county infirmaries and places of detention for juveniles for the purpose of obtaining facts pertaining to the usefulness and proper management of the infirmaries and places of detention, and of promoting proper, efficient, and humane administration of those infirmaries and places of detention. A reasonable order of the department fixing minimum standards of sanitation, fire protection, food, and comfortable lodging may be enforced, through mandamus or injunction in the circuit court for the county where the county infirmary or place of detention for the juveniles is located, through proper proceedings instituted by the attorney general on behalf of the department. The burden of proof shall be on the department to establish the reasonableness of the order.

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(*l*) To promulgate by rules a recommended schedule of payment for care and maintenance, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, to be used, as provided by law, in determining the amount of payment to be made by patients, their guardians, or relatives who are liable for the care and maintenance of persons entitled to treatment under the mental health code, Act No. 258 of the Public Acts of 1974, as amended, being sections 330.1001 to 330.2106 of the Michigan Compiled Laws. The department in promulgating the schedule may give consideration to the person's income, the number of other persons he or she is obligated to support, his or her estate, medical and other necessary expenses, and other relevant matters.

(n) To provide or contract for legal services for persons receiving assistance under this act in guardianship and support proceedings.

(p) To provide services to adults and aging persons, which shall include:

(*i*) Services for the blind in accordance with the rehabilitation act of 1973, 29 U.S.C. 701 to 796i.

(*ii*) Services authorized in title XX of the social security act, 42 U.S.C. 1397 to 1397e.

(q) To license and regulate child care organizations and programs as described in Act No. 116 of the Public Acts of 1973, as amended, being sections 722.111 to 722.128 of the Michigan Compiled Laws.

(2) Other sections of this act notwithstanding, all powers and duties of the county social services boards to develop, implement, and administer a program of general public relief, are transferred to the state department effective beginning with the first county fiscal year following December 1, 1975. However, in a county that operates a patient care management system pursuant to section 66j, the county social services board may change the eligibility standards and coverages for medical care for persons eligible for services under a patient care management system subject to the consent of the county board of commissioners, or, in a charter county, subject to the consent of the county board of commissioners and the county executive.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1944, 1st Ex. Sess., Act 30, Imd. Eff. Mar. 3, 1944;—CL 1948, 400.14;—Am. 1949, Act 142, Eff. Sept. 23, 1949;—Am. 1951, Act 248, Imd. Eff. June 15, 1951;—Am. 1952, Act 237, Eff. Sept. 18, 1952;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1964, Act 220, Eff. Aug. 28, 1964;—Am. 1965, Act 283, Imd. Eff. July 22, 1965;—Am. 1966, Act 229, Imd. Eff. July 11, 1966;—Am. 1969, Act 310, Eff. Mar. 20, 1970;—Am. 1975, Act 237, Eff. Dec. 1, 1975;—Am. 1976, Act 136, Imd. Eff. May 27, 1976;—Am. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1982, Act 519, Eff. Mar. 30, 1983;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Compiler's note: For transfer of powers and duties related to the inspection of infirmaries and places of detention for juveniles from the family independence agency to the director of the department of consumer and industry services, see E.R.O. No. 1996-2, compiled at MCL 445.2001 of the Michigan Compiled Laws.

Popular name: Act 280

Administrative rules: R 400.1 et seq.; R 400.1101 et seq.; R 400.3351; R 400.3401 et seq.; R 400.3501 et seq.; R 400.7101 et seq.; R 400.7171 et seq.; R 400.7391 et seq.; and R 400.7701 et seq. of the Michigan Administrative Code.

400.14a State department; camps, purposes.

Sec. 14a. The state department shall be authorized to operate camps for the furnishing of relief and medical care to homeless and unattached persons.

History: Add. 1945, Act 157, Eff. Sept. 6, 1945;—CL 1948, 400.14a.

Popular name: Act 280

400.14b Family planning services; notice of availability, contents; referral, drugs and appliances, rules and regulations.

Sec. 14b. The director, and under his supervision, county, city and district departments of social welfare, may provide written or oral notice to recipients of public assistance of the availability of advice and treatment in family planning. Such notice shall include a statement that receipt of public assistance is in no way dependent upon a request or nonrequest for family planning services. No effort shall be made to suggest or persuade recipients to request or not request family planning services. The director, and under his supervision, county, city and district departments of social welfare may make available upon request of recipients of public assistance advice and treatment in family planning by referral upon request of the recipient to a licensed medical doctor, licensed osteopathic physician, public agency or, on a contractual basis, to a private agency of the recipient's choice. Necessary drugs and recognized medical appliances for use in family planning may also be made available through licensed pharmacists upon prescription issued by a licensed physician. Such family planning services shall be made available in accordance with rules and regulations promulgated by the director under law.

History: Add. 1965, Act 302, Imd. Eff. July 22, 1965;—Am. 1966, Act 248, Imd. Eff. July 11, 1966.

Popular name: Act 280

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400.14c Minimum housing standards; establishment, annual review; use of relief grants.

Sec. 14c. The state department shall establish minimum housing standards for the maintenance of health and decency which shall be not less than those required by the provisions of Act No. 167 of the Public Acts of 1917, as amended, being sections 125.401 to 125.519 of the Compiled Laws of 1948, and shall review the standards at least once each year. No general relief authorized under this act shall be used to pay rent for any dwelling that does not meet the standard established under this section.

History: Add. 1966, Act 192, Imd. Eff. July 1, 1966;—Am. 1967, Act 76, Imd. Eff. June 21, 1967.

Popular name: Act 280

400.14d Juvenile residential care facility in county with population less than 50,000; direct care worker; qualification; conflict with administrative rule.

Sec. 14d. (1) In a juvenile residential care facility operated by a court under section 14 that is located in a county with a population of less than 50,000, a direct care worker is qualified to and shall be allowed to work in the facility if he or she has completed high school or obtained a general equivalency diploma (GED).

(2) If an administrative rule conflicts with the provisions of this section, the provisions of this section prevail.

History: Add. 2018, Act 12, Eff. May 7, 2018.

Popular name: Act 280

400.14e Federal food stamps; distribution by mail; rules.

Sec. 14e. The department, within 60 days after the effective date of this section, may establish a system for distribution by mail of federal food stamps to persons who make the required payments therefor to the department before the mailing. The department may promulgate rules to implement this section.

History: Add. 1971, Act 177, Imd. Eff. Dec. 2, 1971.

Popular name: Act 280

400.14f Administration of program or performance of duty; contract with private individual or agency.

Sec. 14f. Subject to section 5 of article XI of the state constitution of 1963, the family independence agency may contract with a private individual or agency to administer a program created under this act or to perform a duty of the family independence agency under this act.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996.

Popular name: Act 280

400.14g Pilot projects.

Sec. 14g. In order to achieve more efficient and effective use of funds for public assistance, to reduce dependency, or to improve the living conditions and increase the incomes of individuals receiving public assistance, the family independence agency may establish and conduct pilot projects in 1 or more county or district offices. The family independence agency may apply different policies in the pilot programs than it applies in the rest of the county or district offices, and may conduct the pilot projects as long as is necessary to provide a reasonable test of the policy being evaluated. Pilot projects shall be consistent with principles and goals set forth in this act.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996.

Popular name: Act 280

400.14h Electronic benefit transfer system; use for food stamp distribution; rescission of rules.

Sec. 14h. (1) The family independence agency shall use an electronic benefit transfer system for food stamp distribution.

(2) To the extent that rules or parts of rules promulgated under this act conflict with the provisions of this section, the provisions of this section supersede those rules or parts of rules.

(3) The following rules are rescinded:

(a) R 400.3002 of the Michigan administrative code.

(b) R 400.3003 of the Michigan administrative code.

(c) R 400.3004 of the Michigan administrative code.

(d) R 400.3007 of the Michigan administrative code.

(e) R 400.3008 of the Michigan administrative code.

(f) R 400.3012 of the Michigan administrative code.

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(g) R 400.3013 of the Michigan administrative code.

(h) R 400.3125 of the Michigan administrative code.

History: Add. 2001, Act 280, Eff. Mar. 22, 2002.

Popular name: Act 280

400.14i Repealed. 2011, Act 240, Imd. Eff. Dec. 2, 2011.

Compiler's note: The repealed section pertained to applicability of MCL 400.56f(3)(c), (e), and (f) and 400.57g(4), (5), (6), and (7).

400.14j Issuance of food assistance benefits; number of times per month.

Sec. 14j. (1) If the department determines that an individual is eligible for food assistance benefits of $100.00 per month or more, the department shall issue his or her regular food assistance benefits 2 times each month. The department may continue to issue food assistance benefits 1 time per month to recipients receiving food assistance benefits that are less than $100.00 per month. The department may continue to issue food assistance benefits on a staggered basis by case ending digit.

(2) This section does not apply to issuing initial food assistance benefits, retroactive food assistance benefits, or supplemental food assistance benefits.

History: Add. 2008, Act 107, Imd. Eff. Apr. 25, 2008.

Popular name: Act 280

400.14*l* Replacement cost of electronic benefits transfer card.

Sec. 14*l*. (1) A recipient shall not be charged for the replacement cost of an electronic benefits transfer card the first time the card is replaced. A recipient is responsible for payment of the actual replacement cost and administrative cost of the electronic benefits transfer card for each subsequent time the card is replaced.

(2) The payment required under subsection (1) shall be deducted from the recipient's benefits.

History: Add. 2012, Act 196, Imd. Eff. June 26, 2012.

400.15 Gifts; acceptance by commission; duties of attorney general.

Sec. 15. The commission may receive on behalf of the state of Michigan any grant, devise, bequest, donation, gift, or assignment of money, bonds, or choses in action, or any property, real or personal, and accept that property, so that the right and title to that property shall pass to the state of Michigan. All bonds, notes, or choses in action, or the proceeds of the bonds, notes, or choses in action when collected, and all other property or things of value received by the commission shall be reported to the state treasurer and used for the purposes set forth in the grant, devise, bequest, donation, gift, or assignment if such purposes are within the powers conferred on the commission. If it is necessary to protect or assert the right or title to any property received or derived under this section, or to collect or reduce into possession any bond, note, bill, or chose in action, the attorney general, upon request of the commission, shall take the necessary and proper proceedings and bring suit in the name of the commission on behalf of the state of Michigan in any court of competent jurisdiction, state or federal, and prosecute all such suits.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.15;—Am. 2002, Act 84, Imd. Eff. Mar. 26, 2002.

Popular name: Act 280

400.16 Budget; preparation by commission, submission to governor.

Sec. 16. The commission shall prepare and submit to the governor or budget director the estimated needs and costs to operate the state department, including the several institutions under the jurisdiction of the department, in accordance with the requirements of the laws of this state.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.16.

Popular name: Act 280

400.17 Report of program goals and biennial report to governor and legislature; recommendations.

Sec. 17. (1) The family independence agency shall establish program goals consistent with section 57a and shall report these goals to the governor and the legislature within 6 months after the effective date of this subsection.

(2) The family independence agency shall prepare and on or before the fifteenth day of December in each even-numbered year make a report to the governor, setting forth the operation of the family independence agency during the preceding fiscal biennium of the state, reporting on progress toward the goals established under subsection (1), and containing any findings and recommendations of the family independence agency. The report shall also be submitted to the legislature.

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History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.17;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1995, Act 223, Eff. Mar. 28, 1996.

Popular name: Act 280

400.18 Appropriations for general public relief; distribution of moneys to county and district departments; assumption of program costs by state; exclusions; county expenditures and costs; reimbursement of county payments; difference between county's shared revenue and county's costs; supplemental security income and aid to dependent children; general public relief payments.

Sec. 18. (1) The state department shall provide for the distribution of such moneys as shall be appropriated by the legislature for public welfare grants in respect to general relief, but not expenditures in respect to a county medical care facility, other infirmary care in a county infirmary not existing on January 1, 1981, or inpatient hospitalization, to the several county and district departments of social services on the basis of monthly reporting to the department by the county departments.

(2) Effective December 1, 1979 in counties having a fiscal year beginning December 1 and ending November 30 and effective January 1, 1980 in counties having a fiscal year beginning January 1 and ending December 31, all expenditures for a program of general public relief shall be appropriated from the general revenues of the state. The state shall assume the full cost of the general relief program for public welfare costs including total administration, but excluding costs incurred for county hospitalization and in the administration of and care in a county medical care facility, or infirmary not existing on January 1, 1981.

(3) The period from December 1, 1974 through November 30, 1975 shall be the base year upon which the reductions of county expenditures shall be determined in those counties having a fiscal year beginning December 1 and ending November 30. The period from January 1, 1975 through December 31, 1975 shall be the base year upon which the reductions of county expenditures shall be determined in those counties having a fiscal year beginning January 1 and ending December 31. Net county costs shall be the county portion of matchable general relief expenditures which were matched by state funds during the base year, not to exceed 1 mill of the county's 1974 state equalized valuation, as certified by the director. During the first county fiscal year following the base year, county costs shall be 80% of the net county costs. During the second county fiscal year following the base year, county costs shall be 60% of the net county costs. During the third county fiscal year following the base year, county costs shall be 40% of the net county costs. During the fourth county fiscal year following the base year, county costs shall be 20% of the net county costs.

(4) Beginning with the first county fiscal year following the base year, county payments to recipients of general public relief shall be reimbursed monthly by the state for all costs certified by the director, less the county costs.

(5) The difference between a county's unrestricted state shared revenue distributed during the county's 1976 fiscal year pursuant to the provisions of Act No. 140 of the Public Acts of 1971, as amended, being sections 141.901 to 141.921 of the Michigan Compiled Laws, and the county's costs for general public relief in its 1976 fiscal year as certified by the department of management and budget shall be at least 30 cents per capita more than the difference between the county's unrestricted state shared revenue distributed during the county's 1975 fiscal year and the net county costs for general public relief as defined in subsection (3). Any additional amount required to fulfill the provisions of this subsection shall be paid from the general fund and remitted to the county with the June, 1977 payment provided under subsection (4).

(6) The state department shall provide for the allocation and distribution of such moneys as shall be appropriated by the legislature or received from the federal government, for supplemental security income and aid to dependent children to be disbursed in accordance with the laws of this state.

(7) The state department may make arrangements to disburse amounts to general public relief recipients after determination of the recipients' needs by county. The arrangements shall permit general public relief payments by the department and voucher or vendor payments for persons entitled to general public relief not involving any federal funds, where the well-being of the recipient or the protection of general public relief funds makes such payments desirable. Nothing in this section or act shall be construed, however, as limiting the right of the state department to make warrants payable to and deliver same to any creditor of a recipient of general public relief who has provided food, shelter, or public utility service to such recipients at the request of the state department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.18;—Am. 1950, Ex. Sess., Act 19, Eff. Mar. 31, 1951;—Am. 1951, Act 125, Eff. Sept. 28, 1951;—Am. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1975, Act 237, Eff. Dec. 1, 1975;—Am. 1980, Act 486, Imd. Eff. Jan. 20, 1981.

Popular name: Act 280

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400.18a Friend of the court incentive payment program; establishment; activities; subsection (1) inapplicable to certain judicial circuits; annual appropriation.

Sec. 18a. (1) A friend of the court incentive payment program is established in the state department. Except as provided in subsection (2), the program shall consist of the following activities:

(a) An annual determination of the gross amount of child support payments collected by each office of the friend of the court for families receiving aid to families with dependent children, which amount is collected under the friend of the court act, Act No. 294 of the Public Acts of 1982, being sections 552.501 to 552.535 of the Michigan Compiled Laws, or the support and parenting time enforcement act, Act No. 295 of the Public Acts of 1982, being sections 552.601 to 552.650 of the Michigan Compiled Laws.

(b) The remitting of 3% of the amount determined under subdivision (a) for an office, to the county treasurer for the appropriate county or counties for deposit in the friend of the court fund created in section 2530 of the revised judicature act of 1961, Act No. 236 of the Public Acts of 1961, being section 600.2530 of the Michigan Compiled Laws, if the county board of commissioners makes appropriations in accordance with that section.

(2) Subsection (1) does not apply to any judicial circuit in which the employees serving in the circuit court are employees of the state judicial council.

(3) The legislature annually shall appropriate to the state department an amount equal to the amount required to be remitted under subsection (1)(b).

History: Add. 1982, Act 298, Eff. July 1, 1983;—Am. 1996, Act 12, Eff. June 1, 1996.

Compiler's note: Former MCL 400.18a, providing for allocation and distribution of aid to persons permanently and totally disabled, was repealed by Act 286 of 1957.

Popular name: Act 280

400.18b Repealed. 1975, Act 280, Eff. Jan. 1, 1976.

Compiler's note: The repealed section pertained to distribution of moneys for foster care of children.

Popular name: Act 280

400.18c Foster care of children; use of licensed child caring institutions or placement agencies; supervision by county department; standards of care and service; placement of child at least 16 but less than 21 years of age or at least 18 but less than 21 years of age.

Sec. 18c. (1) Foster care financed by a county department shall be provided by the use of licensed child caring institutions or placement agencies, in accordance with the needs of the child, or if licensed child caring institutions or placement agencies are not available, or there is a religious conflict, foster care shall be provided under the direct supervision of the county department, which care shall meet the following standards of care and service:

(a) Personnel engaged in placement and supervision of children in foster care shall have qualifying training and experience.

(b) Adequate records shall be maintained with information on the physical and mental health of the child, his or her emotional stability and family background, together with the reasons for the child's placement away from home to aid in planning for any child placed by the department, toward the end that the child may be reunited with his or her family as soon as it appears possible.

(c) Family foster homes used by the department shall be selected with consideration of the religious, racial, and cultural background of the child to be placed and children thus placed shall be visited in these homes at least once a month.

(2) The department may place a child who is at least 16 but less than 21 years of age in an unlicensed residence to live independently, or in the unlicensed residence of an adult who has no supervisory responsibility for the child, if the department maintains supervisory responsibility for that child. If the child is at least 18 but less than 21 years of age, he or she must meet the requirements of the young adult voluntary foster care act.

History: Add. 1955, Act 113, Eff. Oct. 14, 1955;—Am. 2011, Act 230, Imd. Eff. Nov. 22, 2011.

Popular name: Act 280

400.18d Foster care of children; county emergency receiving facility for temporary care, standards.

Sec. 18d. The county department of social welfare, upon authorization of the county board of supervisors, may operate an emergency receiving facility for the temporary care of homeless, dependent or neglected children for whom such care is necessary, pending foster care placement or restoration to their own homes or

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any other plan deemed best for the health, safety and welfare of such children. The county department operating an emergency receiving facility shall maintain the standards of the state department established in respect to places of detention for juveniles under section 14 of this act.

History: Add. 1958, Act 29, Eff. Sept. 13, 1958.

Popular name: Act 280

400.18e State plan for foster care; focus groups; establishment; funds.

Sec. 18e. (1) The family independence agency shall establish and administer a state plan for foster care according to the provisions of part E of title IV of the social security act, 42 USC 670 to 679b. The state plan shall include programs and services that promote, implement, and support foster care focus groups. When developing and annually reviewing the state plans to carry out foster care policy and services, the family independence agency shall utilize input from locally-based foster care focus groups.

(2) Foster care focus groups shall be composed of youth in foster care or independent living programs, youth previously in foster care, foster parents or relatives caring for youth in foster care, and adults previously in foster care or independent living programs. The majority of the focus group consists of youth in foster care or independent living programs.

(3) In order to inform the legislature, the executive office, the judiciary, and the public of the needs and interests of youth in foster care, foster parents, and relatives caring for youth in foster care, the foster care focus groups are encouraged to be established in both of the following:

(a) Licensed child placing agencies with which the family independence agency contracts for youth foster care services that have an annual average daily foster care caseload of 150 or more cases or that derives more than 50% of its operating budget from contracts with the family independence agency for youth foster care services.

(b) Counties in which the family independence agency has an annual average daily foster care caseload of 150 or more cases.

(4) State and federal funds appropriated to implement state plans in compliance with part E of title IV of the social security act, 42 USC 670 to 679b and state laws may be used to meet the provisions of this section.

History: Add. 2004, Act 18, Imd. Eff. Mar. 4, 2004.

Popular name: Act 280

400.19 Powers and duties as to Michigan employment institution for blind; transfer to state department.

Sec. 19. The powers and duties vested by law in the board of corrections and charities and transferred to the state welfare commission, in the state welfare department, in the director of the state welfare department, in the state welfare commission and in the state institute commission as relating to the Michigan employment institution for the blind at Saginaw are hereby transferred to and vested in the state department of social welfare herein created. Immediately on the taking effect of this act, the departments, boards, commissions and officers whose powers and duties are hereby transferred shall be abolished, and, whenever reference thereto is made in any law of the state, reference shall be deemed to be intended to be made to the state department of social welfare.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.19;—Am. 1957, Act 95, Eff. Sept. 27, 1957.

Popular name: Act 280

400.20 Powers and duties as to social welfare; transfer to state department.

Sec. 20. All of the powers and duties prescribed in any law of this state with respect to any subject matter vested in the state department of social welfare shall be transferred to and be vested in said department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.20.

Popular name: Act 280

400.21 Refusal of access or information to social welfare commission; misdemeanor.

Sec. 21. Any officer, superintendent or employe of any institution, home, hospital, or other facility subject to inspection under the provisions of this act, who shall refuse to admit any member of the commission, or any duly authorized agent of the state department, acting within the scope of his authority, for the purpose of inspection, or who shall refuse or neglect to furnish any information required by the commission, or said duly authorized agent, acting within the scope of his authority, shall be guilty of a misdemeanor and shall be punished as provided in the laws of this state.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.21.

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Popular name: Act 280

OLD AGE ASSISTANCE, AID TO DEPENDENT CHILDREN, AND AID TO THE BLIND

***** *400.22.added THIS ADDED SECTION IS EFFECTIVE MARCH 21, 2019* *****

400.22.added Program of all-inclusive care for the elderly (PACE); requirements; "PACE" defined.

Sec. 22. (1) As used in this section, "Program of All-Inclusive Care for the Elderly" or "PACE" means an innovative model of community-based care that enables elderly individuals, who are certified as needing nursing facility care, to live as independently as possible.

(2) A prospective PACE organization can be a not-for-profit, for-profit, or public entity that is primarily engaged in providing PACE services and participates in both Medicare and Medicaid. Michigan licensure as a health care entity is not required. An unlicensed PACE entity may serve any eligible enrollee. A prospective PACE entity must meet the federal requirements for a PACE organization, enroll as a Michigan Medicaid provider, and complete a feasibility study.

(3) A prospective PACE organization must submit both of the following to the department:

(a) Not later than 90 calendar days after submitting a letter of intent, a feasibility study.

(b) Not later than 1 year after the department approves the feasibility study, a provider application.

(4) When submitting a letter of intent, a prospective PACE entity must state in the application the service area proposed for the PACE program. If the state determines that there is unmet need in a designated geographic area already covered by an existing PACE organization, the department must notify that PACE organization in a reasonable amount of time, and that PACE organization must be given the opportunity to submit a plan to expand capacity sufficient to accommodate need. The department must give the existing PACE program 6 months from notice of the determination of unmet need to submit an expansion plan. If the existing PACE organization fails to submit a reasonable plan for expansion within 6 months, the state may allow proposals from other PACE organizations. The department shall work with the PACE Association of Michigan and other appropriate provider representatives to develop an acceptable methodology to determine unmet need.

History: Add. 2018, Act 447, Eff. Mar. 21, 2019.

Compiler's note: Former MCL 400.22, which pertained to the creation of the bureau of social security, was repealed by Act 95 of 1957, Eff. Sept. 27, 1957.

Popular name: Act 280

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400.23, 400.23a Repealed. 1968, Act 117, Imd. Eff. June 11, 1968.

Compiler's note: The repealed sections pertained to old age assistance and other aid; county bureau; director of state department.

Popular name: Act 280

400.24 Rules; printing of blanks and books of record; eligibility and financial standards for general relief and burial.

Sec. 24. The state department, for programs financed in whole or in part with federal funds, may make such rules as are necessary for guiding and regulating the county departments of social services. The state department shall prepare and have printed all blanks and books of record used in the county departments of social services, to the end that a uniform system shall be employed in all counties. The state department shall establish eligibility and financial standards for all forms of general public relief and burial. Differential area standards may be established to correspond to the characteristics of the community. Recommended standards for general relief and burial shall annually be submitted to the department by the Michigan county social services association. A county social services board which is dissatisfied with general relief and burial standards established for its county shall, within 30 days after notification of those standards, be given the opportunity to meet with the state director to review the determination. Eligibility and financial standards shall not be affected by a county decision to supplement individual payments to recipients of general public relief.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.24;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1975, Act 237, Eff. Dec. 1, 1975.

Popular name: Act 280

Administrative rules: R 400.1 et seq. and R 400.3501 et seq. of the Michigan Administrative Code.

400.25 Application for assistance; form, oath; third party; political or religious affiliations.

Sec. 25. An applicant for assistance or a third party acting responsibly in his behalf shall deliver his

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application in writing to the county department of social services in the manner and form prescribed by the state department. All statements in the application shall be over the signature or witnessed mark of the applicant or such third party and shall include a declaration under the penalties of perjury that the application has been examined by or read to the applicant or third party, and, to the best of the applicant's or third party's knowledge, that all facts are true in each material point and are complete; and the applicant or third party shall empower the county department of social services and the state department to obtain all necessary information concerning the recipient of social services for whom the application is made and his resources in order to determine the eligibility of the applicant. No question, inquiry or recommendation shall relate to the political opinions or religious affiliations of any person, and no grant or denial of aid under this act shall be in any manner affected or influenced by such opinions or affiliations.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 225, Imd. Eff. May 18, 1945;—CL 1948, 400.25;—Am. 1950, 1st Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1968, Act 232, Imd. Eff. June 26, 1968.

Popular name: Act 280

400.25a-400.27 Repealed. 1973, Act 189, Imd. Eff. Jan. 8, 1974.

Compiler's note: The repealed sections pertained to aid to permanently and totally disabled, and to eligibility and ineligibility for old age assistance.

Popular name: Act 280

400.28 Old age assistance; amount; aid by persons not responsible for support, effect.

Sec. 28. The amount of assistance shall be fixed with due regard to the condition of the individual and community and the circumstances in each case. When an applicant is not receiving adequate support from a husband or wife responsible under the laws of this state to furnish such support, free board and lodging supplied to an applicant because of his or her necessity by a friend or relative who is not responsible for applicant's support shall not be grounds for refusing aid.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1941, Act 186, Eff. Jan. 10, 1942;—Am. 1945, Act 225, Imd. Eff. May 18, 1945;—Am. 1947, Act 301, Imd. Eff. June 30, 1947;—Am. 1948, 1st Ex. Sess., Act 8, Imd. Eff. Apr. 28, 1948;—CL 1948, 400.28;—Am. 1949, Act 77, Eff. July 1, 1949;—Am. 1951, 1st Ex. Sess., Act 2, Imd. Eff. Aug. 23, 1951;—Am. 1954, Act 45, Eff. Aug. 13, 1954;—Am. 1956, Act 25, Eff. July 1, 1956;—Am. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1964, Act 202, Imd. Eff. May 22, 1964;—Am. 1966, Act 228, Eff. Aug. 1, 1966;—Am. 1970, Act 87, Imd. Eff. July 20, 1970.

Popular name: Act 280

400.29 Repealed. 1968, Act 117, Imd. Eff. June 11, 1968.

Compiler's note: The repealed section pertained to social welfare act; old age assistance; and effect of income from mortgages and land contracts.

Former law: See section 29 of Act 280 of 1939, which was repealed by Act 186 of 1941.

Popular name: Act 280

400.30 Repealed. 1965, Act 211, Imd. Eff. July 16, 1965.

Compiler's note: The repealed section provided formula for computing income from non-homestead real property held by applicant for assistance.

Popular name: Act 280

400.31 Residence of spouse living separate and apart.

Sec. 31. For the purposes of this act, the residence of 1 spouse shall not be considered the residence of the other spouse if they are living separate and apart, and in that case each may have a separate residence dependent upon proof of the fact and not upon legal presumption. A person shall not be, because thereof, precluded from acquiring or retaining a legal residence or settlement.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 225, Imd. Eff. May 18, 1945;—CL 1948, 400.31;—Am. 1983, Act 213, Imd. Eff. Nov. 11, 1983.

Popular name: Act 280

400.32 Continuation of assistance if person moves or is taken to another county; transfer of records; "resident of state" defined; continued absence from state as abandonment of residence; inapplicability of certain rules; requirements applicable to medical assistance eligibility; residence of husband and wife living separate and apart.

Sec. 32. (1) Subject to section 14g, a person qualified for and receiving assistance under this act in any county in this state who moves or is taken to another county in this state may continue to receive assistance in

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the county to which the person has moved or is taken, and the county family independence agency of the county from which the person has moved shall transfer all necessary records relating to the person to the county family independence agency of the county to which the person has moved.

(2) For purposes of the family independence program and medical assistance under this act, a resident of this state is a person who is living in this state voluntarily with the intention of making his or her home in this state and not for a temporary purpose and who is not receiving assistance from another state. For purposes of medical assistance, a resident of this state also includes a person and the dependents of a person who, at the time of application, is living in this state, is not receiving assistance from another state, and entered the state with a job commitment or seeking employment in this state. For purposes of determining eligibility to receive assistance under this act, excluding recipients of supplemental security income under title XVI of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1381 to 1382, and 1383 to 1383d or state supplementation under this act, the continued absence of a recipient from this state, unless the absence is temporary or intent to return is established as provided by applicable federal regulations, shall constitute abandonment by the recipient of residence in this state. Any existing rule that has been promulgated under this act that defines temporary absence for the purpose of eligibility for family independence assistance or medical assistance, or that provides for continuation of eligibility if the absence is not temporary, is not applicable.

(3) For purposes of medical assistance eligibility the requirements in subsection (2) apply except as otherwise provided in federal regulations for the administration of the medical assistance program under title XIX of the social security act, 42 U.S.C. 1396 to 1396g and 1396i to 1396v.

(4) The residence of a husband shall not be considered to be the residence of the wife if they are living separate and apart. If a husband and wife are living separate and apart, each may have a separate residence dependent upon proof of the fact and not upon legal presumption. This subsection shall not be construed to prohibit a person from acquiring or retaining a legal residence.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 121, Eff. Sept. 6, 1945;—CL 1948, 400.32;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1980, Act 122, Imd. Eff. May 21, 1980;—Am. 1995, Act 223, Eff. Mar. 28, 1996.

Popular name: Act 280

400.33 Repealed. 1968, Act 268, Eff. Nov. 15, 1968.

Compiler's note: The repealed section pertained to funeral expenses of social welfare recipient; recovery; recovery from estate of deceased or surviving spouse.

Popular name: Act 280

400.34, 400.34a Repealed. 1965, Act 305, Imd. Eff. July 22, 1965.

Compiler's note: The repealed sections gave state preferred claim against deceased's estate for funeral expenses paid by state.

Popular name: Act 280

400.35 Records; confidentiality; rules for use.

Sec. 35. Notwithstanding section 2(6), records relating to categorical assistance, including medical assistance, shall be confidential and shall not be open to inspection except as prescribed in section 64. The state department of social services may promulgate and enforce rules for the use of the records as may be necessary for purposes related to federal, state, or local public assistance, pursuant to Act No. 306 of the Public Acts of 1969, as amended.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.35;—Am. 1950, Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1966, Act 321, Eff. Sept. 1, 1966;—Am. 1978, Act 224, Imd. Eff. June 13, 1978.

Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.36 County department; compliance with state requirements as to payment of assistance.

Sec. 36. When assistance is given to any person under the provisions of this act with respect to old age assistance, aid to dependent children, aid to the blind, and aid to the permanently and totally disabled, the county department of social welfare shall comply with all requirements of the state department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.36;—Am. 1950, Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.37 Application for assistance; investigation, hearing, appeal.

Sec. 37. Whenever an application made for assistance, the county department of social welfare shall make a thorough investigation and report to the state department in the manner prescribed by it, giving its

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recommendation of the amount of assistance, if any, to be allowed. If the application be disallowed, or if the applicant is dissatisfied with the amount of assistance he is receiving, or is to receive, he may demand, in writing, a hearing of his case, as provided for in section 9 or section 65. The applicant or recipient may appeal to the circuit court of the county in which he resides, which court shall have power to review questions of law involved in any final decision or determination of the state department. Said petition shall be filed within 30 days of the receipt of such decision or determination. The petitioner shall not be required to furnish any bond and costs shall not be taxed against him. If the court shall decide in favor of the petitioner, assistance shall be paid from the first day of the month following the date of the application therefor or of the date of the original application for the relief in question.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 225, Imd. Eff. May 18, 1945;—CL 1948, 400.37;—Am. 1950, Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.38 Assistance; determination of amount; authorizations; warrants, delivery.

Sec. 38. Upon receipt of the recommendations of the county department of social services, the state department shall determine the amount of categorical assistance to be allowed monthly, if any, and the date for which the first payment shall be made, to be payable as the state department shall decide. If a person has been authorized to receive a payment in respect to his requirements for any month for categorical assistance, no assistance shall be allowed nor shall eligibility exist for him for that month for any other categorical assistance. The state department shall cause to be made due record of all authorizations of assistance with the address of the recipient and shall furnish the county department of social services with a copy thereof. Whenever payment of assistance is made, warrants shall be drawn upon the appropriation made therefor, or other moneys available for these forms of assistance, and delivered to the recipients, or third parties acting responsibly in their behalf or the providers of goods or services authorized by the state department in accordance with such regulations as may be made by the state department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.38;—Am. 1951, Act 264, Eff. Sept. 28, 1951;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1968, Act 232, Imd. Eff. June 26, 1968.

Popular name: Act 280

400.39 Payment of assistance to applicant or recipient; cancellation of assistance checks.

Sec. 39. All old age assistance, aid to dependent children, aid to the blind, and aid to the permanently and totally disabled, given under this act shall be paid directly to the applicant or recipient except that (1) if a legal guardian has been duly appointed for such applicant or recipient, the assistance may be paid to such guardian for the benefit of such applicant or recipient, or (2) if the state department has entered into a contractual arrangement or agreement or has authorized goods or services from a provider including hospitalization or medical care in behalf of the applicant or recipient, a portion of the assistance as determined by the state department may be paid directly to the contractor or provider, or (3) if necessary, as determined by the state department and in conformance with the rules of the department of health, education and welfare and such rules as shall be developed by the state department, the assistance may be paid to a third party interested in and acting responsibly in behalf of such applicant or recipient for the benefit of such applicant or recipient. (4) Any assistance checks not indorsed during the lifetime of the recipient shall be null and void and shall be returned to the state department and canceled.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.39;—Am. 1951, Act 264, Eff. Sept. 28, 1951;—Am. 1968, Act 232, Imd. Eff. June 26, 1968;—Am. 1972, Act 367, Imd. Eff. Jan. 9, 1973.

Popular name: Act 280

400.40 Repealed. 1995, Act 223, Eff. Mar. 28, 1996.

Compiler's note: The repealed section pertained to the financial report filed by a recipient.

Popular name: Act 280

400.41 Report by recipient on acquisition of property; recommendations of county department.

Sec. 41. If at any time after approval of a grant of assistance the recipient, or the spouse of the recipient, becomes possessed of any property or income of which the county department of social welfare has no knowledge, it shall be the duty of the recipient to notify said county department of social welfare which shall report and make recommendations to the state department which in turn may cancel, suspend or alter the certificate of allowance.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.41;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

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Popular name: Act 280

400.42 Repealed. 1973, Act 189, Imd. Eff. Jan. 8, 1974.

Compiler's note: The repealed section pertained to payments to institutionalized persons.

Popular name: Act 280

400.43 Assistance; periodical review, power to alter or revoke, appeal.

Sec. 43. All assistance granted under this act shall be reconsidered from time to time, or as frequently as may be required by the state department. After further investigation by the county department of social welfare, the amount and manner of giving assistance may be changed, or the assistance may be withdrawn if the state department finds the recipient's circumstances have changed sufficiently to warrant such action. It shall be within the power of the state department at any time to cancel and revoke assistance for cause, and it may for cause suspend payments for assistance as it may deem proper, subject to appeal and hearing by the recipient as provided for in section 9. The provisions of this section shall be mandatory only with respect to old age assistance, aid to dependent children, aid to the blind, aid to the permanently and totally disabled or any other function financed in whole or in part by federal funds.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.43;—Am. 1950, Ex. Sess., Act 42, Eff. Oct. 1, 1950;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.43a Definitions; recovery of overpayments; overpayment as result of criminal act; waiver; report of cost effectiveness.

Sec. 43a. (1) As used in this section:

(a) "Overpayment" means the difference between the amount of assistance to which an individual is entitled under this act and the amount of assistance actually received by that individual.

(b) "Public assistance recipient" means an individual who is receiving, or who did receive, assistance under this act.

(2) The state department shall take all necessary steps to recover an overpayment made to a public assistance recipient, including, but not limited to, administrative action or action in a court of competent jurisdiction. Procedures for the recovery of overpayments made under federally assisted programs shall be consistent with federal law and regulations.

(3) This section does not limit or prevent the criminal prosecution of an individual who has received an overpayment as a result of fraud or other criminal act.

(4) In the case of an individual who is no longer a public assistance recipient, the state department may waive recovery of an overpayment if the cost of recovery is equal to or greater than the amount of the overpayment or if the error was made by the department. Except as prohibited by federal law or regulation, the state department may waive recovery of an overpayment if the recovery would result in undue hardship to the public assistance recipient, as determined by the state department.

(5) The state department shall report annually to the legislature on the cost effectiveness of the recovery of overpayments described in this section.

History: Add. 1993, Act 41, Imd. Eff. May 27, 1993.

Popular name: Act 280

400.43b Office of inspector general; establishment as criminal justice agency; duties.

Sec. 43b. An office of inspector general is established as a criminal justice agency in the family independence agency. The primary duty of the inspector general is to investigate cases of alleged fraud within the department. The inspector general shall also perform the following activities:

(a) Investigate fraud, waste, and abuse in the programs administered by the family independence agency.

(b) Make referrals for prosecution and disposition of appropriate cases as determined by the inspector general.

(c) Review administrative policies, practices, and procedures.

(d) Make recommendations to improve program integrity and accountability.

History: Add. 2002, Act 573, Eff. Dec. 1, 2002.

Compiler's note: For transfer of powers and duties of office of inspector general from department of human services to department of health and human services office of inspector general, and abolishment of the position of inspector general, see E.R.O. No. 2015-1, compiled at MCL 400.227.

Popular name: Act 280

400.44 Fee for obtaining certain benefits; condition; amount; definitions.

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Sec. 44. (1) The state department shall pay a fee to an attorney or other competent professional who represents a person in obtaining benefits from the federal social security administration in a proceeding establishing retroactive benefits for that person under the supplemental security income for the aged, blind, and disabled program, title XVI of the social security act, 42 U.S.C. 1381 to 1383c. The department shall pay a fee under this section only if the proceeding results in direct reimbursement to the department of interim assistance paid to the person for the period covered by the award. Direct reimbursement means a lump sum payment to the department from the social security administration or from the person who received the interim assistance. A fee shall not be paid under this section for a reimbursement that results from an initial determination only, and a fee paid shall not exceed the amount of interim assistance reimbursed to the state pursuant to that proceeding. The fee paid by the state under this section in any individual proceeding shall be determined based on the amount billed and the amount of reimbursed interim assistance. If the reimbursement for interim assistance is $500.00 or less, the fee shall be the lesser of the amount billed or the amount reimbursed to the department. If the reimbursement for interim assistance is $500.01 to $2,000.00, the fee shall be the lesser of the amount billed or $500.00. If the reimbursement for interim assistance exceeds $2,000.00, the fee shall be the lesser of the amount billed or 25% of the reimbursement. A fee paid under this section shall constitute full payment for services rendered.

(2) As used in this section:

(a) "Interim assistance" means general assistance paid to a person during the period covered by the award.

(b) "Other competent professional" means a person who has demonstrated a professional competence in, and a working knowledge of, social security law and regulations under titles II and XVI of the social security act, and who is trained to represent persons in appeals before the social security administration.

History: Add. 1987, Act 184, Imd. Eff. Nov. 30, 1987;—Am. 1990, Act 270, Imd. Eff. Nov. 28, 1990.

Compiler's note: Former MCL 400.44, which gave bureau of social security power to prescribe number of recipients in any year in which moneys for old age assistance were not adequate to provide reasonable assistance for all applications, was repealed by Act 264 of 1951, Eff. Sept. 28, 1951.

Popular name: Act 280

COUNTY DEPARTMENT OF SOCIAL SERVICES

400.45 Creation, powers, duties, and composition of county family independence agency; powers and duties of family independence agency board; offices; salary and expenses; prohibition; appointment and oath of board members; appointment and qualifications of directors, employees, and assistants; evaluation of county director; availability of writings to public.

Sec. 45. (1) A county family independence agency is created in each county of this state, which shall possess the powers granted and perform the duties imposed in this act. The county family independence agency shall consist of a county family independence agency board and the director of the county family independence agency, together with assistants and employees as may be necessary to operate the county family independence agency. As used in this act, references to "county department of social services" or "county department" mean the county family independence agency and references to "county social services board" and "county board" mean the county family independence agency board.

(2) The powers and duties of the county family independence agency board include all of the following:

(a) Supervision of and responsibility for the administration of the county infirmary and county medical care facility and child caring institution, except as provided in sections 55(c) and 58.

(b) Conduct, in conjunction with the family independence agency, an annual review of social service programs operating within the county.

(c) Development of policy and supervision of the administration of social service programs authorized by the county board of commissioners or financed solely from county funds or county administered funds.

(d) Development and administration of employment programs and work training projects complementary to and not in conflict with state programs.

(e) Review and submit recommendations on contracts involving programs administered by the family independence agency proposed to be entered into between the family independence agency and public or private agencies within the county including proposed purchases of service contracts from applicant agencies within the county eligible for funding under title XX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1397 to 1397f. A contract shall not be entered into between the family independence agency and a public or private agency within the county until the board has been provided an opportunity for review of the contract. The board shall be advised by the family independence agency within 30 days after contracts have been signed with an explanation of the differences between contracts recommended by the board and those

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actually entered into.

(f) Act as the agent for the county board of commissioners in the development of coordinated or consolidated approaches to the delivery of social services and cooperative service delivery arrangements between the family independence agency and each public and private social service agency within the county.

(g) Represent the county board of commissioners in all negotiations between the county and the family independence agency.

(h) Make annual policy recommendations to the Michigan county social services association on annual departmental appropriations, priorities for utilization of title XX funds, eligibility standards for general public relief and burial, employment programs, work training projects, and other related issues.

(3) The family independence agency shall provide suitable office accommodations for programs funded in whole or in part with state funds. The county family independence agency board shall review and recommend to the director proposed office sites within the county. The director shall notify the board before final site selection with an explanation of the selection of a site other than that proposed by the board.

(4) The salary and expenses of each member of the county board shall be fixed by the county board of commissioners according to the amount of time the member devotes to the performance of official duties. A member of the county board may not serve as the director or an employee of the county family independence agency. The members of the county boards shall be appointed at the annual October session of commissioners, and members shall qualify by taking and filing the oath of office with the county clerk, and shall assume their duties as prescribed by this act not later than November 1 of the year appointed.

(5) The director, employees, and assistants of the county family independence agency shall be appointed by the family independence agency from among persons certified as qualified by the state civil service commission. The county family independence agency board shall review the qualifications of and interview each applicant for the position of county family independence agency director. The county director shall be appointed from among persons certified as eligible and recommended by the family independence agency and by the county board. These appointment provisions do not apply under conditions of reduction in state work force, in which case the administrative employment preference rules for bumping promulgated by the Michigan civil service commission apply. The county board shall advise and make recommendations to the state director regarding the performance of the county director within 6 months after the appointment of the county director and annually after that time. A copy of each evaluation shall be provided to the county director.

(6) Except as prescribed in sections 35 and 64, a writing prepared, owned, used, in the possession of, or retained by the county family independence agency in the performance of an official function shall be made available to the public in compliance with the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 53, Eff. Sept. 6, 1945;—CL 1948, 400.45;—Am. 1965, Act 401, Imd. Eff. Oct. 17, 1965;—Am. 1966, Act 74, Imd. Eff. June 10, 1966;—Am. 1975, Act 237, Eff. Dec. 1, 1975;—Am. 1978, Act 224, Imd. Eff. June 13, 1978;—Am. 1995, Act 223, Eff. Mar. 28, 1996.

Popular name: Act 280

400.46 County social services board; administration of powers and duties; appointment and terms of members; oath; vacancies; conducting business at public meeting; notice; quorum; meetings; chairperson; effect of failure to attend meetings; compensation and expenses; availability of writings to public.

Sec. 46. (1) The administration of the powers and duties of the county department shall be vested in a county social services board of 3 members, appointed from persons residing within the county and not holding an elective office, for 3-year terms as follows: 2 members shall be appointed by the county board of commissioners, and 1 member by the director of social services. Members appointed before October 27, 1965, shall continue in office until the expiration of their terms and until successors are appointed and qualified. Each member shall qualify by taking and filing with the county clerk the constitutional oath of office, and shall hold office until the appointment and qualification of a successor. Vacancies in the membership of the board shall be filled for the expiration of the unexpired term, in the same manner as provided for appointment of the original members.

(2) The business which the county social services board may perform shall be conducted at a public meeting of the county social services board held in compliance with Act No. 267 of the Public Acts of 1976. Public notice of the time, date, and place of the meeting shall be given in the manner required by Act No. 267 of the Public Acts of 1976. A majority of the board constitutes a quorum for the transaction of business. The board shall meet on the call of the chairperson, or on a written request to the chairperson signed by 2 members of the board, or at times and places as prescribed by the rules of the board. The board shall hold not less than

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12 meetings each fiscal year with an interval of not more than 5 weeks between 2 meetings.

(3) At the first meeting following the appointment of a new member to the board, the members shall choose 1 member as chairperson, who shall continue to act as chairperson of the board until the selection of a successor.

(4) If a member of the county social services board, upon receiving notification, fails to attend 3 consecutive regularly scheduled meetings of the board, the county board of commissioners after notification from the county social services board of the failure of a member to attend without reasonable cause such as illness or other circumstances beyond the member's control shall by formal vote excuse the member or declare the office vacant. The vacancy shall be filled for the remainder of the unexpired term in the same manner as the original appointment was made.

(5) Members of the board shall be reimbursed for necessary travel and other expenses, and shall be paid such amount as shall be fixed by the board of commissioners or board of county auditors.

(6) Except as prescribed in sections 35 and 64, a writing prepared, owned, used, in the possession of, or retained by the county social services board in the performance of an official function shall be made available to the public in compliance with Act No. 442 of the Public Acts of 1976.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1945, Act 53, Eff. Sept. 6, 1945;—CL 1948, 400.46;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1967, Act 60, Imd. Eff. June 20, 1967;—Am. 1978, Act 224, Imd. Eff. June 13, 1978.

Popular name: Act 280

400.47 Organization of district department of social welfare and medical relief; powers and duties vested in district social welfare board and medical advisory council; appointment, qualifications, and terms of members; applicability of references; chairperson; conducting business at public meeting; notice; availability of writings to public.

Sec. 47. (1) Two or more counties may organize a district department of social welfare and medical relief by a majority vote of the members elect of the county board of commissioners of each county. The administration of the powers and duties of the department shall be vested in a district social welfare board and medical advisory council. The district social welfare board and medical advisory council shall consist of members appointed from persons who are residents within the district, for 3-year terms as follows: 1 member shall be appointed by the state social welfare commission and the county board of commissioners of each county included in the district shall each appoint 2 members. Of the members first appointed the member appointed by the state social welfare commission shall be appointed for a term of 1 year; 1 member appointed by the county board of commissioners of each county shall be appointed for the term of 2 years, and 1 member for the term of 3 years. A reference in this act to a county department of social services or to a county social services board, shall be deemed to apply to a district department of social welfare or a district social welfare board, where a district has been created as provided in this section. A member of a district board shall not hold an elective office. The members of the district social welfare board shall choose a chairperson as provided in section 46.

(2) The business which a district social welfare board may perform shall be conducted at a public meeting of the board held in compliance with Act No. 267 of the Public Acts of 1976. Public notice of the time, date, and place of the meeting shall be given in the manner required by Act No. 267 of the Public Acts of 1976.

(3) Except as prescribed in sections 35 and 64, a writing prepared, owned, used, in the possession of, or retained by a district department of social welfare or a district social welfare board in the performance of an official function shall be made available to the public in compliance with Act No. 442 of the Public Acts of 1976.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.47;—Am. 1978, Act 224, Imd. Eff. June 13, 1978.

Popular name: Act 280

400.48 Organization of counties into single administrative unit; appointment of director.

Sec. 48. Subject to the provisions of this subsection, the department director may organize not more than 3 counties into a single administrative unit for purposes of administrative efficiency. Before a decision is made to organize counties into a single administrative unit as allowed under this section, the department shall have a formal consultation with the boards of those counties. The director of the single administrative unit shall be appointed by the department from among persons certified as eligible and recommended by the department and by all of the affected county boards. If the affected county boards are unable to reach agreement on recommended candidates within 3 months after being notified of a vacancy, the director of the single administrative unit shall be appointed by the department from among persons certified as eligible and recommended by the department and by 1 or more of the affected county boards.

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History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 1996, Act 423, Imd. Eff. Nov. 22, 1996;—Am. 2010, Act 212, Imd. Eff. Nov. 17, 2010.

Compiler's note: Former MCL 400.48, which pertained to city department of social welfare, was repealed by Act 117 of 1968, Imd. Eff. June 11, 1968.

Popular name: Act 280

400.49 Director of county or district board; employment; duties; assistants; requirements; compensation and expenses; supplementary salary.

Sec. 49. Any county or district board shall employ a director, who shall be the executive officer and secretary of the board, and shall be responsible to the board for the performance of his duties associated with those social service functions financed by the county. The director and his assistants shall hold no partisan elective office, shall devote their entire time to the performance of the duties of their office, and shall receive such compensation as shall be fixed by the state civil service commission, together with their actual and necessary traveling and other expenses incurred in the discharge of their official duties. Unless disapproved by the state civil service commission, the county board, with the approval of the county board of commissioners, may provide a supplementary salary to that fixed by the state civil service commission in remuneration for those duties of the director and his assistants if deemed justifiable, associated with the administration of those forms of relief or other welfare programs not wholly or in part financed by federal funds. The cost shall be deemed for all purposes a proper county expense.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.49;—Am. 1953, Act 78, Eff. Oct. 2, 1953;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1966, Act 143, Imd. Eff. June 24, 1966;—Am. 1975, Act 237, Eff. Dec. 1, 1975.

Popular name: Act 280

400.50 County employee; unauthorized transfer of public relief recipient, misdemeanor.

Sec. 50. Any county employee or officer who transports, brings or causes to be transported or brought, any other person receiving general relief, hospitalization or infirmary care, or in need of general relief, hospitalization or infirmary care from any county or from any city operating a separate department of social welfare under this act into any other county or city operating a separate department without legal authority and there leave the person receiving general relief or in need of general relief; or who induces such person by threat or other means to remove to another county or city operating a separate department, with the intent to make the county or city to which the removal is made chargeable with the support of the person receiving or in need of public assistance, is guilty of a misdemeanor.

History: Add. 1961, Act 184, Eff. Sept. 8, 1961.

Compiler's note: Former MCL 400.50, deriving from Act 280 of 1939 and authorizing employment of supervisor of bureau of social aid, was repealed by Act 95 of 1957.

Popular name: Act 280

400.51 County board; executive heads of institutions and assistants, appointment, compensation and expenses.

Sec. 51. The county board may appoint an executive head of any institution under the supervision and jurisdiction of the board, and may employ such assistants and employes and incur such other expenses as may be necessary to carry out the provisions of this act. The compensation of all assistants and employes, and the number thereof, shall be within the funds made available therefor. Such assistants and employes shall receive their actual and necessary traveling and other expenses incurred in the discharge of their official duties.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.51.

Popular name: Act 280

400.52 County department; rules and regulations; review, copies, filing; audit of case records; withholding fund.

Sec. 52. The governing board of each county, city and district department shall adopt rules and regulations governing the policies of the board, which rules and regulations shall not be in violation of any express provision of state law. Said rules and regulations shall be reviewed by such governing board at least once in each year. Copies of such rules and regulations shall be forthwith filed with the state department. The state department is hereby authorized to provide for the audit of the case records of the several county, city and district departments with respect to general public relief as defined in section 18, and is further authorized to withhold the distribution of state funds, otherwise required by section 18, in respect to cases for which the relief granted is deemed to be in violation of state law or the rules and regulations of the state department or of the respective boards and filed with the state department. The respective boards shall comply with and be

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governed by the rules and regulations of the state department only as to those forms of relief which are wholly or in part financed by federal funds.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.52;—Am. 1950, Ex. Sess., Act 29, Eff. Mar. 31, 1951;—Am. 1951, Act 127, Eff. Sept. 28, 1951;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

Administrative rules: R 400.1 et seq. and R 400.3501 et seq. of the Michigan Administrative Code.

400.53 County board; cooperation with state department.

Sec. 53. Said board shall cooperate with the state department of social welfare in handling the welfare and relief problems and needs of the people of its county, and to such end may adopt any plan or plans required or desirable in order to participate in the distribution of federal or state moneys, or in order to receive the assistance of the federal or state governments. The board may adopt any rules and regulations or do any act in order to enable participation of the county in any such plan or plans.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.53.

Popular name: Act 280

400.54 County board; prevention of social disabilities, restoration of individuals to self support.

Sec. 54. In the administration of the powers and duties assigned to the department, the board, shall, insofar as possible, place emphasis upon the prevention of social disabilities, the removal of causes of such disabilities, and the restoration of individuals to self support and to normal conditions of life.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.54.

Popular name: Act 280

400.55 Administration of public welfare program by county department.

Sec. 55. The county department shall administer a public welfare program, as follows:

(a) To grant general assistance, including medical care and care in the county medical care facility, but not including hospitalization and infirmary care except for care in the county medical care facility or a county infirmary existing on January 1, 1981, to any person domiciled in the county who has a legal settlement in this state. General assistance may also be granted to a person who has a legal settlement in this state but no domicile in the county and a recoupment may be made when appropriate in the manner provided in cases of emergency hospitalization under this act. In a temporary emergency, general assistance may be given to indigents without a settlement in this state as the county department considers necessary, including, if other funds are not available for the purpose, all necessary expenses in transporting an indigent to his or her domicile in this state, or in another state or nation, when information reasonably tends to show that the person has a home available in his or her place of domicile in this state or a legal residence in another state or nation. A legal settlement in this state is acquired by an emancipated person who has lived continuously in this state for 1 year with the intent to make it his or her home and who, during the 1-year period has not received public assistance, other than assistance received during and as a direct result of a civil defense emergency, or support from relatives. Time spent in a public institution shall not be counted in determining settlement. A legal settlement shall be lost by remaining away from this state for an uninterrupted period of 1 year except that absence from this state for labor or other special or temporary purpose shall not occasion loss of settlement.

(b) To administer categorical assistance including medical care.

(c) To supervise and be responsible for the operation of the county infirmary and county medical care facility. In a county having a population of 1,000,000 or more that maintains a county infirmary or county hospital or a joint infirmary and hospital providing for mental patients, the institution and the admissions to the institution are subject to the control of a board to be known as the board of county institutions. The board shall consist of 5 members appointed by the county board of commissioners, except that in a county having a board of county auditors, 3 members of the board of county institutions shall be appointed by the county board of commissioners and 2 members shall be appointed by the board of county auditors. Each member of the board shall hold office for a term and receive compensation as the county board of commissioners provides by ordinance. In relation to the administration of the institutions the board has and succeeds to all powers and duties formerly vested by law, general, local or special, in the superintendents of the poor in the county and the board of county institutions as constituted on April 13, 1943. The board of county institutions of the county may also maintain outpatient facilities for the treatment of needy persons suffering from mental disorders. The board also has the same powers as are given to the county board in section 78.

(d) To furnish in all cases, insofar as practicable, care and treatment that will tend to restore needy persons

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to a condition of financial and social independence.

(e) To require that each applicant shall furnish proof satisfactory to the county board that the applicant is entitled to the aid, assistance, or benefit sought.

(f) To investigate, in respect to each application for any form of public aid or assistance, the circumstances of the applicant, both at the time of application and periodically during the receipt of aid or assistance.

(g) To maintain adequate social and financial records pertaining to each recipient of aid or assistance and so far as is practicable engage in the prevention of social disabilities.

(h) Except as otherwise provided in this subdivision, to investigate, when requested by the probate court or the family division of circuit court, matters pertaining to dependent, neglected, and delinquent children and wayward minors under the court's jurisdiction, to provide supervision and foster care as provided by court order, and to furnish the court, on request, investigational service in respect to the hospitalization of children under the program of services for children and youth with special health care needs established under part 58 of the public health code, 1978 PA 368, MCL 333.5801 to 333.5879, which services shall include the follow-up investigation and continuing observations. If the county is a county juvenile agency as defined in section 2 of the county juvenile agency act, 1998 PA 518, MCL 45.622, the county department's obligations under this subdivision are limited to public wards within the county's jurisdiction under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309, and county juvenile agency services as defined in section 117a.

(i) To assist other departments, agencies, and institutions of the federal, state, and county governments, when requested, in performing services in conformity with the purposes of this act.

(j) To assist in the development of sound programs and standards of child welfare, and promote programs and policies looking toward the prevention of dependency, neglect, and delinquency and other conditions affecting adversely the welfare of families and children.

(k) To create within the county department a division of medical care. The county board may appoint a properly qualified and licensed doctor of medicine as the head of the division and an advisory committee. The advisory committee shall consist of 1 doctor of medicine, nominated by the county medical society; 1 dentist, nominated by the district dental society; and 1 pharmacist, nominated by the district pharmaceutical association, to assist in formulating policies of medical care and auditing and reviewing bills. "Medical care" as used in this act means medical care rendered under the supervision of a licensed physician in an organized out-patient department of a hospital licensed by the department of community health under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260, or home and office attendance by a physician, osteopathic physician and surgeon, or podiatrist licensed or otherwise authorized to engage in practice under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838; and when prescribed by the physician, osteopathic physician and surgeon, or podiatrist, diagnostic services requiring the use of equipment not available in his or her offices, if the services do not require overnight care, dental service, optometric service, bedside nursing service in the home, or pharmaceutical service. The private physician-patient relationship shall be maintained. The normal relationships between the recipients of dental, optometric, nursing, and pharmaceutical services, and the services furnished by a physician, osteopathic physician and surgeon, podiatrist, or a chiropractor licensed or otherwise authorized to engage in practice under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, and the persons furnishing these services shall be maintained. This section does not affect the office of a city physician or city pharmacist established under a city charter, a county health officer, or the medical superintendent of a county hospital. This section permits the use of a case management system, a patient care management system, or other alternative system for providing medical care.

(*l*) To cause to be suitably buried the body of a deceased indigent person who has a domicile in the county, when requested by the person's relative or friend, or of a stranger, when requested by a public official following an inquest.

(m) To administer additional welfare functions as are vested in the department, including hospitalization.

(n) To act as an agent for the state department in matters requested by the state department under the rules of the state department.

(o) To provide temporary general assistance for each family found ineligible for family independence assistance by reason of unsuitable family home as provided in section 56.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—Am. 1941, Act 343, Eff. Jan. 10, 1942;—Am. 1943, Act 85, Eff. July 30, 1943;—CL 1948, 400.55;—Am. 1951, Act 248, Imd. Eff. June 15, 1951;—Am. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961;—Am. 1962, Act 195, Imd. Eff. June 4, 1962;—Am. 1963, Act 141, Eff. Sept. 6, 1963;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1966, Act 258, Imd. Eff. July 11, 1966;—Am. 1980, Act 486, Imd. Eff. Jan. 20, 1981;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987;—Am. 1998, Act 516, Imd. Eff. Jan. 12, 1999;—Am. 2015, Act 90, Imd. Eff. June 25, 2015.

Compiler's note: For transfer of policymaking, administration, and all related functions for the assistance to disabled persons' portion

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of the General Assistance Program provided for in MCL 400.55 of the Michigan Compiled Laws from the county departments to the Office of Income Assistance of the Family Services Administration of the Department of Social Services, see E.R.O. No. 1991-14, compiled at MCL 400.222 of the Michigan Compiled Laws.

Former law: See Act 85 of 1943.

Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.55a General assistance; eligibility of applicant; determination; failure of employable person to participate in approved project or to accept employment.

Sec. 55a. (1) In determining the eligibility of an applicant for general assistance, and before granting the assistance, except temporary assistance pending disposition of the case, the county and district departments of social services shall conform to the following:

(a) Require each applicant entitled to alimony or separate maintenance to seek the assistance of the friend of the court.

(b) Clear with the proper legal authorities the case of an applicant who is deserted by his or her spouse to determine the advisability of legal action to obtain support.

(c) If it is indicated that eligibility for benefits from other programs such as unemployment compensation, old-age and survivors insurance benefits, federal veterans' benefits, aid to families with dependent children, or supplemental security income exists, secure a clearance in writing with each appropriate agency.

(d) Require an employable person to work on a work relief or work training project, or other departmental-approved activity, if available, in return for assistance given. A person participating in a work relief or work training project shall be entitled to the benefits provided by Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws. All work relief or work training projects or other departmental-approved activities authorized by this section shall be subject to all of the following conditions:

(*i*) Any person required to work on an approved project or activity, upon claiming to be physically incapable to work when so assigned, shall be given a thorough medical examination by competent medical authorities to ascertain his or her ability to participate in the required project or activity.

(*ii*) Each person assigned to an approved project or activity may be required to register for employment with the Michigan employment security commission, if the service is available, and to investigate all bona fide employment opportunities.

(e) Determine that each employable applicant, mentally and physically able to work, is not currently refusing to accept available employment for which wages not less than the usual rate paid by that employer for the particular kind of employment are being offered.

(2) Any employable person who, without good cause, fails to participate in an approved project or activity or to accept available lawful employment for which wages, not less than the usual rate paid by that employer for that particular kind of employment are being offered, shall have his or her needs removed from the general assistance grant and shall not be eligible for general assistance for 3 months.

History: Add. 1951, Act 128, Eff. Sept. 28, 1951;—Am. 1964, Act 148, Eff. Aug. 28, 1964;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1980, Act 251, Eff. Dec. 12, 1980.

Compiler's note: Former MCL 400.55a, deriving from Act 20 of 1950, Ex. Sess., and pertaining to eligibility of applicants for general public relief, was held invalid in Op. Atty. Gen. 1951-1952, No. 1367.

Popular name: Act 280

400.55b Repealed. 1983, Act 213, Imd. Eff. Nov. 11, 1983.

Compiler's note: The repealed section pertained to the acquisition and holding of a legal settlement by an emancipated person.

Popular name: Act 280

400.55c Repealed. 1995, Act 223, Eff. Mar. 28, 1996.

Compiler's note: The repealed section pertained to the employment skills training program.

Popular name: Act 280

400.56 Repealed. 1995, Act 223, Eff. Mar. 28, 1996.

Compiler's note: The repealed section pertained to provisions applicable to aid to dependent children.

Popular name: Act 280

400.56a, 400.56b Repealed. 1964, Act 3, Imd. Eff. Mar. 13, 1964.

Compiler's note: The repealed sections defined "dependent child" and "unemployed parent" and provided for cooperative arrangements for job placement of unemployed parents.

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Popular name: Act 280

400.56c-400.56g Repealed. 1995, Act 223, Eff. Mar. 28, 1996.

Compiler's note: The repealed sections pertained to requirements applicable to dependent children, job placement services, programs operated under provisions of title IV of social security act, and eligibility requirements for aid to dependent children.

Popular name: Act 280

400.56i Individuals having history of domestic violence; establishment and enforcement of standards and procedures; certification by governor; collection and compilation of data; annual report.

Sec. 56i. (1) The family independence agency shall establish and enforce standards and procedures to do all of the following:

(a) Screen and identify individuals who are receiving assistance under section 57b who have a history of domestic violence, while maintaining the confidentiality of that information.

(b) Refer those individuals identified under subdivision (a) to counseling and supportive services.

(c) In accordance with a determination of good cause, waive certain program requirements of the family independence program established in section 57a in cases where compliance with those requirements would make it more difficult for individuals receiving assistance to escape domestic violence or would unfairly penalize individuals who are or have been victimized by domestic violence or individuals who are at risk of further domestic violence.

(2) The family independence agency shall include in the state plan required for federal temporary assistance for needy families block grants a certification by the governor that the state has established and is enforcing the standards and procedures described in subsection (1).

(3) The family independence agency shall collect and compile data regarding administration of the waiver authorized under subsection (1)(c), including information regarding individuals screened and identified under subsection (1)(a) and information regarding individuals actually granted a waiver. The family independence agency shall annually report to the legislature on the information collected and compiled under this subsection.

History: Add. 1997, Act 162, Eff. Oct. 1, 1998.

Popular name: Act 280

****** 400.57 THIS SECTION IS AMENDED EFFECTIVE JANUARY 1, 2020: See 400.57.amended ******

400.57 Definitions.

Sec. 57. (1) As used in this section and sections 57a to 57v:

(a) "Adult-supervised household" means either of the following:

(*i*) The place of residence of a parent, stepparent, or legal guardian of a minor parent.

(*ii*) A living arrangement not described in subparagraph (*i*) that the department approves as a family setting that provides care and control of a minor parent and his or her child and supportive services including, but not limited to, counseling, guidance, or supervision.

(b) "Caretaker" means an individual who is acting as parent for a child in the absence or because of the disability of the child's parent or stepparent and who is the child's legal guardian, grandparent, great grandparent, great-great grandparent, sibling, stepsibling, aunt, great aunt, great-great aunt, uncle, great uncle, great-great uncle, nephew, niece, first cousin, or first cousin once-removed, a spouse of any person listed above, a parent of the putative father, or an unrelated individual aged 21 or older whose appointment as legal guardian of the child is pending.

(c) "Child" means an individual who is not emancipated under 1968 PA 293, MCL 722.1 to 722.6, who lives with a parent or caretaker, and who is either of the following:

(*i*) Under the age of 18.

(*ii*) Age 18 and a full-time high school student.

(d) "Family" means 1 or more of the following:

(*i*) A household consisting of a child and either of the following:

(A) A parent or stepparent of the child.

(B) A caretaker of the child.

(*ii*) A pregnant woman.

(*iii*) A parent of a child in foster care.

(e) "Family independence program assistance" means financial assistance provided to a family under the family independence program.

(f) "Family independence program assistance group" means all those members of a program group who

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receive family independence program assistance.

(g) "Family independence program" means the program of financial assistance established under section 57a.

(h) "Family self-sufficiency plan" means a document described in section 57e that is executed by a family in return for receiving family independence program assistance.

(i) "JET program" means the jobs, education and training program administered by the Michigan economic development corporation or a successor entity for applicants and recipients of family independence program assistance or a successor program. A reference to the JET program means the PATH program.

(j) "Medical review team" means the team composed of a disability examiner and a physician as a medical consultant who certifies disability for the purpose of eligibility for assistance under this act.

(k) "Negative action period" means the time frame a client is given notice for a benefit decrease or closure of the family independence program benefit.

(*l*) "Minor parent" means an individual under the age of 18 who is not emancipated under 1968 PA 293, MCL 722.1 to 722.6, and who is either the biological parent of a child living in the same household or a pregnant woman.

(m) "PATH program" means the PATH: partnership. accountability. training. hope. work partnership program.

(n) "Payment standard" means the standard upon which family independence program assistance benefits are based.

(o) "Program group" means a family and all those individuals living with a family whose income and assets are considered for purposes of determining financial eligibility for family independence program assistance.

(p) "Recipient" means an individual receiving family independence program assistance.

(q) "Substance abuse" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

(r) "Substance abuse treatment" means outpatient or inpatient services or participation in alcoholics anonymous or a similar program.

(s) "Supplemental security income" means the program of supplemental security income provided under title XVI.

(2) A reference in this act to "aid to dependent children" or "aid to families with dependent children" means "family independence program assistance".

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2006, Act 471, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2014, Act 375, Eff. Jan. 1, 2016.

Compiler's note: Former MCL 400.57, which pertained to eligibility for aid to blind, was repealed by Act 189 of 1973, Imd. Eff. Jan. 8, 1974.

Popular name: Act 280

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***** *400.57.amended THIS AMENDED SECTION IS EFFECTIVE JANUARY 1, 2020* *****

400.57.amended Definitions.

Sec. 57. (1) As used in this section and sections 57a to 57z:

(a) "Adult-supervised household" means either of the following:

(*i*) The place of residence of a parent, stepparent, or legal guardian of a minor parent.

(*ii*) A living arrangement not described in subparagraph (*i*) that the department approves as a family setting that provides care and control of a minor parent and his or her child and supportive services including, but not limited to, counseling, guidance, or supervision.

(b) "Caretaker" means an individual who is acting as parent for a child in the absence or because of the disability of the child's parent or stepparent and who is the child's legal guardian, grandparent, great grandparent, great-great grandparent, sibling, stepsibling, aunt, great aunt, great-great aunt, uncle, great uncle, great-great uncle, nephew, niece, first cousin, or first cousin once-removed, a spouse of any person listed above, a parent of the putative father, or an unrelated individual aged 21 or older whose appointment as legal guardian of the child is pending.

(c) "Child" means an individual who is not emancipated under 1968 PA 293, MCL 722.1 to 722.6, who lives with a parent or caretaker, and who is either of the following:

(*i*) Under the age of 18.

(*ii*) Age 18 and a full-time high school student.

(d) "Family" means 1 or more of the following:

(*i*) A household consisting of a child and either of the following:

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(A) A parent or stepparent of the child.

(B) A caretaker of the child.

(*ii*) A pregnant woman.

(*iii*) A parent of a child in foster care.

(e) "Family independence program assistance" means financial assistance provided to a family under the family independence program.

(f) "Family independence program assistance group" means all those members of a program group who receive family independence program assistance.

(g) "Family independence program" means the program of financial assistance established under section 57a.

(h) "Family self-sufficiency plan" means a document described in section 57e that is executed by a family in return for receiving family independence program assistance.

(i) "Medical review team" means the team composed of a disability examiner and a physician as a medical consultant who certifies disability for the purpose of eligibility for assistance under this act.

(j) "Negative action period" means the time frame a client is given notice for a benefit decrease or closure of the family independence program benefit.

(k) "Minor parent" means an individual under the age of 18 who is not emancipated under 1968 PA 293, MCL 722.1 to 722.6, and who is either the biological parent of a child living in the same household or a pregnant woman.

(*l*) "PATH program" means the PATH: partnership. accountability. training. hope. work partnership program. A reference to the JET program means the PATH program.

(m) "Payment standard" means the standard upon which family independence program assistance benefits are based.

(n) "Program group" means a family and all those individuals living with a family whose income and assets are considered for purposes of determining financial eligibility for family independence program assistance, except as provided in section 57a(6).

(o) "Recipient" means an individual receiving family independence program assistance.

(p) "Substance abuse" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

(q) "Substance abuse treatment" means outpatient or inpatient services or participation in Alcoholics Anonymous or a similar program.

(r) "Supplemental security income" means the program of supplemental security income provided under title XVI.

(2) A reference in this act to "aid to dependent children" or "aid to families with dependent children" means "family independence program assistance".

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2006, Act 471, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2014, Act 375, Eff. Jan. 1, 2016;—Am. 2018, Act 574, Eff. Jan. 1, 2020.

Compiler's note: Former MCL 400.57, which pertained to eligibility for aid to blind, was repealed by Act 189 of 1973, Imd. Eff. Jan. 8, 1974.

Popular name: Act 280

***** *400.57a THIS SECTION IS AMENDED EFFECTIVE JANUARY 1, 2020: See 400.57a.amended* *****

400.57a Family independence program; establishment and administration; purpose; establishment of certain requirements by department; assistance to certain program groups prohibited.

Sec. 57a. (1) The department shall establish and administer the family independence program to provide temporary assistance to families who are making efforts to achieve independence. Family independence program assistance is not an entitlement.

(2) The department shall administer the family independence program to accomplish all of the following:

(a) Provide financial support to eligible families while they pursue self-improvement activities and engage in efforts to become financially independent.

(b) Ensure that recipients who are minor parents live in adult-supervised households in order to reduce long-term dependency on financial assistance.

(c) Assist families in determining and overcoming the barriers preventing them from achieving financial independence.

(d) Ensure that families pursue other sources of support available to them.

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(3) The department shall establish income and asset levels for eligibility, types of income and assets to be considered in making eligibility determinations, payment standards, composition of the program group and the family independence program assistance group, program budgeting and accounting methods, and client reporting requirements to meet the following goals:

(a) Efficient, fair, cost-effective administration of the family independence program.

(b) Provision of family independence program assistance to families willing to work toward eventual self-sufficiency.

(4) In accordance with 42 USC 608(a)(7)(A) and 45 CFR 260.31, the department shall not provide family independence program assistance to any program group that includes an adult who has received assistance under any state program funded with temporary assistance for needy families for more than 60 months, whether or not consecutive, after October 1, 1996. This subsection does not apply to a program group that includes an adult who is exempt from participation in the JET program under section 57f(3) or (4)(b), (e), or (f), if that adult also was exempt from participation in the JET program under section 57f(3) or (4)(b), (e), or (f) on the effective date of the 2012 amendatory act that added this subsection. No other provision of this act prohibits the department from terminating family independence program assistance under this subsection.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 1999, Act 26, Eff. Mar. 10, 2000;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2012, Act 607, Imd. Eff. Jan. 9, 2013.

Popular name: Act 280

***** *400.57a.amended THIS AMENDED SECTION IS EFFECTIVE JANUARY 1, 2020* *****

400.57a.amended Family independence program; establishment and administration; purpose; establishment of certain requirements by department; assistance to certain program groups prohibited; determination of financial eligibility.

Sec. 57a. (1) The department shall establish and administer the family independence program to provide temporary assistance to families who are making efforts to achieve independence. Family independence program assistance is not an entitlement.

(2) The department shall administer the family independence program to accomplish all of the following:

(a) Provide financial support to eligible families while they pursue self-improvement activities and engage in efforts to become financially independent.

(b) Ensure that recipients who are minor parents live in adult-supervised households in order to reduce long-term dependency on financial assistance.

(c) Assist families in determining and overcoming the barriers preventing them from achieving financial independence.

(d) Ensure that families pursue other sources of support available to them.

(3) The department shall establish income and asset levels for eligibility, types of income and assets to be considered in making eligibility determinations, payment standards, composition of the program group and the family independence program assistance group, program budgeting and accounting methods, and client reporting requirements to meet the following goals:

(a) Efficient, fair, cost-effective administration of the family independence program.

(b) Provision of family independence program assistance to families willing to work toward eventual self-sufficiency.

(4) In accordance with 42 USC 608(a)(7)(A) and 45 CFR 260.31, the department shall not provide family independence program assistance to any program group that includes an adult who has received assistance under any state program funded with temporary assistance for needy families for more than 60 months, whether or not consecutive, after October 1, 1996. This subsection does not apply to a program group that includes an adult who is exempt from participation in the PATH program under section 57f(3) or (4)(b), (e), or (f), if that adult also was exempt from participation in the former JET program under section 57f(3) or (4)(b), (e), or (f) on January 9, 2013. No other provision of this act prohibits the department from terminating family independence program assistance under this subsection.

(5) Except as provided in subsections (6) and (7), when determining financial eligibility for family independence program assistance, the department shall disregard the income of a new parent or new stepparent, who becomes a new program group member as the result of marriage, from 1 month after the date of the marriage until 18 months after that date unless the income disregard results in a decrease of eligible assistance. Disregard of a new parent's or new stepparent's income only applies if the program group's income and assets do not exceed twice the income and asset limits set by the department.

(6) A new parent or stepparent described in subsection (5) and his or her children shall not be included in determining an increase in the size of the recipient's program group. If the recipient wishes to increase the size

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of his or her program group as a result of marriage, he or she may choose to reject the income disregard described in subsection (5). If the recipient rejects the income disregard described in subsection (5), his or her new spouse and the spouse's children, as determined by the department under federal rules and regulations, may be included in determining the size of the recipient's program group.

(7) The income disregard described in subsection (5) and section 57b(1)(b) only applies if the department receives approval from the federal government to implement this program.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 1999, Act 26, Eff. Mar. 10, 2000;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2012, Act 607, Imd. Eff. Jan. 9, 2013;—Am. 2018, Act 574, Eff. Jan. 1, 2020.

Popular name: Act 280

***** *400.57b THIS SECTION IS AMENDED EFFECTIVE JANUARY 1, 2020: See 400.57b.amended* *****

400.57b Family independence program assistance; eligibility requirements generally; requirements applicable to minor parent and minor parent's child; recipient applying for supplemental security income and seeking exemption from PATH program; evaluation and assessment process; contracts; audit; member of family independence program assistance group not meeting attendance requirements of MCL 380.1561; implementation of policy.

Sec. 57b. (1) An individual who meets all of the following requirements is eligible for family independence program assistance:

(a) Is a member of a family or a family independence program assistance group.

(b) Is a member of a program group whose income and assets are less than the income and asset limits set by the department.

(c) In the case of a minor parent, meets the requirements of subsection (2).

(d) Is a United States citizen, a permanent resident alien, or a refugee. If the applicant indicates that he or she is not a United States citizen, the department shall verify the applicant's immigration status using the federal systematic alien verification for entitlements (SAVE) program.

(e) Is a resident of this state as described in section 32.

(f) Meets any other eligibility criteria required for the receipt of federal or state funds or determined by the department to be necessary for the accomplishment of the goals of the family independence program.

(g) Is a member of a program group that meets the requirements of subsection (6).

(2) A minor parent and the minor parent's child shall not receive family independence program assistance unless they live in an adult-supervised household. The family independence program assistance shall be paid on behalf of the minor parent and child to an adult in the adult-supervised household. Child care in conjunction with participation in education, employment readiness, training, or employment programs, that have been approved by the department, shall be provided for the minor parent's child. The minor parent and child shall live with the minor parent's parent, stepparent, or legal guardian unless the department determines that there is good cause for not requiring the minor parent and child to live with a parent, stepparent, or legal guardian. The department shall determine the circumstances that constitute good cause, based on a parent's, stepparent's, or guardian's unavailability or unwillingness or based on a reasonable belief that there is physical, sexual, or substance abuse, or domestic violence, occurring in the household, or that there is other risk to the physical or emotional health or safety of the minor parent or child. If the department determines that there is good cause for not requiring a minor parent to live with a parent, stepparent, or legal guardian, the minor parent and child shall live in another adult-supervised household. A local office director may waive the requirement set forth in this subsection with respect to a minor parent who is at least 17 years of age, attending secondary school full-time, and participating in a department service plan or a teen parenting program, if moving would require the minor parent to change schools.

(3) If a recipient who is otherwise eligible for family independence program assistance under this section is currently applying for supplemental security income and seeking exemption from the PATH program, the recipient shall be evaluated and assessed as provided in this section before a family self-sufficiency plan is developed under section 57e. Based on a report resulting from the evaluation and assessment, the caseworker shall make a determination and referral as follows:

(a) A determination that the recipient is eligible to participate in the PATH program and a referral to the PATH program.

(b) A determination that the recipient is exempt from PATH program participation under section 57f and a referral to a sheltered work environment or subsidized employment.

(c) A determination that the recipient is exempt from PATH program participation under section 57f and a

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referral for supplemental security income advocacy.

(4) The department may contract with a legal services organization to assist recipients with the process for applying for supplemental security income. The department may also contract with a nonprofit rehabilitation organization to perform the evaluation and assessment described under subsection (3). If the department contracts with either a nonprofit legal or rehabilitation services organization, uniform contracts shall be used statewide that include, but are not limited to, uniform rates and performance measures.

(5) The auditor general shall conduct an annual audit of the evaluation and assessment process required under this section and submit a report of his or her findings to the legislature.

(6) Except as provided in subsection (7) and beginning after the date on which the department implements the policy described in subsection (7), a family independence program assistance group shall not receive family independence program assistance if a member of the program group does not meet the attendance requirements of section 1561 of the revised school code, 1976 PA 451, MCL 380.1561, with respect to a child under the age of 16. Except as provided in subsection (7) and beginning after the date on which the department implements the policy described in subsection (7), if a member of the program group does not meet the attendance requirements of section 1561 of the revised school code, 1976 PA 451, MCL 380.1561, with respect to a child age 16 and above, the child shall be removed from the program group. The department shall implement policies in accordance with this subsection that are effective and binding on all program groups and are exempt from the rule promulgation requirements of the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(7) Not later than 1 year after the effective date of the amendatory act that added this subsection, the department shall implement a policy that it must follow before terminating a family independence program assistance group from receiving family independence program assistance as provided in subsection (6) or before removing a child from the program group as provided in subsection (6). The department shall apply the policy described in this subsection before removing a family independence program assistance group from receiving family independence program assistance as described in subsection (6) and before removing a child from a family independence program assistance group as described in subsection (6).

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 1999, Act 9, Eff. Mar. 10, 2000;—Am. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2015, Act 56, Imd. Eff. June 11, 2015.

Popular name: Act 280

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***** *400.57b.amended THIS AMENDED SECTION IS EFFECTIVE JANUARY 1, 2020* *****

400.57b.amended Family independence program assistance; eligibility requirements generally; requirements applicable to minor parent and minor parent's child; recipient applying for supplemental security income and seeking exemption from PATH program; evaluation and assessment process; contracts; audit; member of family independence program assistance group not meeting attendance requirements of MCL 380.1561; implementation of policy.

Sec. 57b. (1) An individual who meets all of the following requirements is eligible for family independence program assistance:

(a) Is a member of a family or a family independence program assistance group.

(b) Is a member of a program group whose income and assets are less than the income and asset limits set by the department. Except as provided in section 57a(6) and (7), when determining a program group's income and assets, the department shall disregard the income and assets of a new parent or new stepparent, who becomes a new program group member as the result of marriage, from 1 month after the date of the marriage until 18 months after that date unless the income and assets disregard results in a decrease of eligible assistance. The disregard of a new parent's or new stepparent's income and assets only applies if the program group's income and assets do not exceed twice the income and asset limits set by the department.

(c) In the case of a minor parent, meets the requirements of subsection (2).

(d) Is a United States citizen, a permanent resident alien, or a refugee. If the applicant indicates that he or she is not a United States citizen, the department shall verify the applicant's immigration status using the federal systematic alien verification for entitlements (SAVE) program.

(e) Is a resident of this state as described in section 32.

(f) Meets any other eligibility criteria required for the receipt of federal or state funds or determined by the department to be necessary for the accomplishment of the goals of the family independence program.

(g) Is a member of a program group that meets the requirements of subsection (6).

(2) A minor parent and the minor parent's child shall not receive family independence program assistance unless they live in an adult-supervised household. The family independence program assistance shall be paid

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on behalf of the minor parent and child to an adult in the adult-supervised household. Child care in conjunction with participation in education, employment readiness, training, or employment programs, that have been approved by the department, shall be provided for the minor parent's child. The minor parent and child shall live with the minor parent's parent, stepparent, or legal guardian unless the department determines that there is good cause for not requiring the minor parent and child to live with a parent, stepparent, or legal guardian. The department shall determine the circumstances that constitute good cause, based on a parent's, stepparent's, or guardian's unavailability or unwillingness or based on a reasonable belief that there is physical, sexual, or substance abuse, or domestic violence, occurring in the household, or that there is other risk to the physical or emotional health or safety of the minor parent or child. If the department determines that there is good cause for not requiring a minor parent to live with a parent, stepparent, or legal guardian, the minor parent and child shall live in another adult-supervised household. A local office director may waive the requirement set forth in this subsection with respect to a minor parent who is at least 17 years of age, attending secondary school full-time, and participating in a department service plan or a teen parenting program, if moving would require the minor parent to change schools.

(3) If a recipient who is otherwise eligible for family independence program assistance under this section is currently applying for supplemental security income and seeking exemption from the PATH program, the recipient shall be evaluated and assessed as provided in this section before a family self-sufficiency plan is developed under section 57e. Based on a report resulting from the evaluation and assessment, the caseworker shall make a determination and referral as follows:

(a) A determination that the recipient is eligible to participate in the PATH program and a referral to the PATH program.

(b) A determination that the recipient is exempt from PATH program participation under section 57f and a referral to a sheltered work environment or subsidized employment.

(c) A determination that the recipient is exempt from PATH program participation under section 57f and a referral for supplemental security income advocacy.

(4) The department may contract with a legal services organization to assist recipients with the process for applying for supplemental security income. The department may also contract with a nonprofit rehabilitation organization to perform the evaluation and assessment described under subsection (3). If the department contracts with either a nonprofit legal or rehabilitation services organization, uniform contracts shall be used statewide that include, but are not limited to, uniform rates and performance measures.

(5) The auditor general shall conduct an annual audit of the evaluation and assessment process required under this section and submit a report of his or her findings to the legislature.

(6) Except as provided in subsection (7) and beginning after the date on which the department implements the policy described in subsection (7), a family independence program assistance group shall not receive family independence program assistance if a member of the program group does not meet the attendance requirements of section 1561 of the revised school code, 1976 PA 451, MCL 380.1561, with respect to a child under the age of 16. Except as provided in subsection (7) and beginning after the date on which the department implements the policy described in subsection (7), if a member of the program group does not meet the attendance requirements of section 1561 of the revised school code, 1976 PA 451, MCL 380.1561, with respect to a child age 16 and above, the child shall be removed from the program group. The department shall implement policies in accordance with this subsection that are effective and binding on all program groups and are exempt from the rule promulgation requirements of the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(7) Not later than June 11, 2016, the department shall implement a policy that it must follow before terminating a family independence program assistance group from receiving family independence program assistance as provided in subsection (6) or before removing a child from the program group as provided in subsection (6). The department shall apply the policy described in this subsection before removing a family independence program assistance group from receiving family independence program assistance as described in subsection (6) and before removing a child from a family independence program assistance group as described in subsection (6).

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 1999, Act 9, Eff. Mar. 10, 2000;—Am. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2015, Act 56, Imd. Eff. June 11, 2015;—Am. 2018, Act 574, Eff. Jan. 1, 2020.

Popular name: Act 280

400.57c Application for assistance by minor parent; duties of department.

Sec. 57c. If a minor parent applies for family independence program assistance, the department shall do all of the following:

(a) Inform the minor parent of the eligibility requirements of section 57b(2) and the circumstances under

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which there is good cause for permitting the minor parent to live in an adult-supervised household other than the home of his or her parent or legal guardian.

(b) Complete a home visit or other appropriate investigation before requiring a minor parent to live with his or her parent, stepparent, or legal guardian.

(c) If applicable, assist the minor parent to find an adult-supervised household in which to live.

(d) Inform the minor parent of the requirement to attend school full-time.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57d Conduct of weekly orientation sessions; development of family self-sufficiency plan; compliance required; penalties; reassessment of recipient's eligibility.

Sec. 57d. (1) The department and the Michigan economic development corporation or a successor entity shall conduct weekly orientation sessions for family independence program assistance applicants. After the department makes an initial determination that an adult or a child aged 16 or older who is not attending elementary or secondary school full-time may be eligible for family independence program assistance and is not exempt from JET program participation under section 57f, that individual shall participate in assigned work-related activities. The individual, the department, and a JET program representative shall develop the family's family self-sufficiency plan in accordance with section 57e.

(2) If an applicant who is not exempt from JET program participation under section 57f fails to cooperate with the JET program or other required employment and training activities, the family is ineligible for family independence program assistance.

(3) The department shall impose penalties under section 57g if the individual fails to comply with the individual's family self-sufficiency plan.

(4) If the individual is complying with the family self-sufficiency plan, the department, a JET program representative, and the recipient may revise the family self-sufficiency plan if necessary and the family independence program assistance group shall continue to receive family independence program assistance so long as the recipients meet family independence program assistance requirements.

(5) The department shall reassess the recipient's eligibility for family independence program assistance every 12 months after the date the application for family independence program assistance was approved. At the time of a reassessment under this subsection, the recipient shall meet with his or her caseworker and JET program representative and redevelop the family self-sufficiency plan.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2001, Act 280, Eff. Mar. 22, 2002;—Am. 2005, Act 323, Imd. Eff. Dec. 27, 2005;—Am. 2007, Act 9, Imd. Eff. May 18, 2007;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57e Family self-sufficiency plan; execution; development; contents; identification of goals; monitoring compliance with plan.

Sec. 57e. (1) Each family receiving family independence program assistance shall execute a family self-sufficiency plan outlining the responsibilities of members of the family independence program assistance group, the contractual nature of family independence program assistance, and the focus on the goal of attaining self-sufficiency. The family self-sufficiency plan shall be developed by the department and the adult family members of the family independence program assistance group with the details of JET program participation to be included in the family self-sufficiency plan being developed by the department, the Michigan economic development corporation or a successor entity, and the adult family members of the family independence program assistance group. Except as described in section 57b, the department shall complete a thorough assessment to facilitate development of the family self-sufficiency plan, including consideration of referral to a life skills program, and determination as to whether the family independence program assistance group's adult members are eligible to participate in the JET program or are exempt from JET program participation under section 57f. The family self-sufficiency plan shall identify compliance goals that are to be met by members of the family independence program assistance group and goals and responsibilities of the members of the family independence program assistance group, the department, and the JET program. The family self-sufficiency plan shall reflect the individual needs and abilities of the particular family, and shall include at least all of the following:

(a) The obligation of each adult and each child aged 16 or older who is not attending elementary or secondary school full-time to participate in the JET program unless exempt under section 57f.

(b) The obligation of each minor parent who has not completed secondary school to attend school.

(c) Except as provided in section 57f(3) and (4), the obligation of each adult to engage in employment, JET program activities, education or training, community service activities, or self-improvement activities, as

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determined appropriate by the department.

(d) The obligation to cooperate in the establishment of paternity and to assign child and spousal support to the department as required by federal law and to cooperate in the procurement of child support, if applicable.

(e) The obligation of a recipient who fails to comply with compliance goals due to substance abuse to participate in substance abuse treatment and submit to any periodic drug testing required by the treatment program.

(f) If the recipient is determined to be eligible to participate in the JET program, the obligation that the requirements of the family self-sufficiency plan must, at a minimum, meet federal guidelines for work participation. Exceptions may be granted if it is determined that the recipient or a family member in the recipient's household has a disability that needs reasonable accommodation as required by section 504 of title V of the rehabilitation act of 1973, 29 USC 794, subtitle A of title II of the Americans with disabilities act of 1990, 42 USC 12131 to 12134, or another identified barrier that interferes with the recipient's ability to participate in required activities. Reasonable accommodation must be made to adjust the number of required hours or the types of activities required to take the identified limitations into account.

(g) The obligation that the recipient must enroll in a GED preparation program, a high school completion program, or a literacy training program, if the department determines the resources are available and the assessment and plan demonstrate that these issues present a barrier to the recipient meeting the requirements in his or her family self-sufficiency plan. This basic educational skills training shall be combined with other occupational skills training, whenever possible, to assure that it can be counted toward federal work participation requirements.

(h) Notification to the recipient of the 48-month lifetime cumulative total for collecting family independence program assistance.

(i) A prohibition on using family independence program assistance to purchase lottery tickets, alcohol, or tobacco, for gambling, or for illegal activities or any other nonessential items.

(j) Information regarding sanctions that shall be imposed under section 57g for noncompliance.

(k) Any other obligation the department determines is necessary to enable the family to achieve independence.

(2) The department shall monitor each family's compliance with the family self-sufficiency plan.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2001, Act 280, Eff. Mar. 22, 2002;—Am. 2006, Act 469, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

***** *400.57f(6) THIS SUBSECTION DOES NOT APPLY AFTER DECEMBER 31, 2013* *****

400.57f Agreement with Michigan economic development corporation or successor entity; administration of PATH program; eligibility; exemptions; temporary exemption; disabled individual; rules; subsection (6) inapplicable after December 31, 2013; "PATH" program defined.

Sec. 57f. (1) The department shall enter into an agreement with the Michigan economic development corporation or a successor entity to facilitate the administration of the PATH program. The department shall make information on the program available to the legislature.

(2) Except as provided in section 57b, at the time the department determines that an individual is eligible to receive family independence program assistance under this act, the department shall determine whether that individual is eligible to participate in the PATH program or if the individual is exempt from PATH program participation under this section. The particular activities in which the recipient is required or authorized to participate, including community service, the number of hours of work required, and other details of the PATH program shall be developed by the department and the Michigan economic development corporation or a successor entity and shall be set forth in the recipient's family self-sufficiency plan. If a recipient has cooperated with the PATH program, the recipient may enroll in a program approved by the local workforce development board. Any and all training or education with the exception of high school completion, GED preparation, and literacy training must be occupationally relevant and in demand in the labor market as determined by the local workforce development board and may be no more than 2 years in duration. Participants must make satisfactory progress while in training or education.

(3) The following individuals are exempt from participation in the PATH program:

(a) A child under the age of 16.

(b) A child age 16 to 18 who is attending elementary or secondary school full-time.

(c) A recipient who has medical documentation of being disabled or medical documentation of an inability to participate in employment or the PATH program for more than 90 days because of a mental or physical

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condition.

(d) A recipient unable to participate as determined by the medical review team.

(e) A recipient aged 65 or older.

(f) A recipient of supplemental security income.

(g) A recipient of retirement, survivor, or disability insurance based on disability or blindness, or a recipient found eligible for retirement, survivor, or disability insurance based on disability or blindness who is in nonpay status.

(4) The department may grant a temporary exemption from participation in the PATH program to any of the following:

(a) An individual who is suffering from a documented short-term mental or physical illness, limitation, or disability that severely restricts his or her ability to participate in PATH program activities. An individual with a documented mental or physical illness, limitation, or disability that does not severely restrict his or her ability to participate in the PATH program shall be required to participate in the PATH program at a medically permissible level. An exemption under this subdivision shall not exceed a period of 90 days without a review by a department caseworker.

(b) An individual for whom certain program requirements have been waived under section 56i. An exemption under this subdivision shall not exceed a period of 90 days without a review by a department caseworker.

(c) A parent with a child under the age of 60 days if that child is in the home or a mother for postpartum recovery up to 60 days after giving birth if that child is not in the home.

(d) A pregnant recipient who, based on medical documentation, is severely restricted in her ability to participate in PATH program activities for the duration of the pregnancy.

(e) The spouse of a recipient who is verified as disabled and living in the home with the spouse if it is verified that the spouse is needed in the home full-time due to the extent of medical care required. An exemption under this subdivision shall not exceed a period of 365 days without a review by a department caseworker.

(f) A parent of a child who is verified as disabled and living in the home with the parent if it is verified that the parent is needed in the home due to the extent of medical care required. If the child attends school, the parent may be referred to the PATH program with limitations. An exemption under this subdivision shall not exceed a period of 365 days without a review by a department caseworker.

(5) An individual is not disabled for purposes of this section if substance abuse is a contributing factor material to the determination of disability.

(6) The department may promulgate rules in accordance with the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, identifying exemptions under this section. The director of the department may grant exemptions for extenuating circumstances beyond the exemptions provided for in this section. The department shall annually provide to the legislature, at the same time as the governor's departmental budget proposal, a report of the number of exemptions issued under this section and the individual reason for those exemptions. This subsection does not apply after December 31, 2013.

(7) As used in this section, "PATH program" means the PATH: partnership. accountability. training. hope. work partnership program.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2001, Act 280, Eff. Mar. 22, 2002;—Am. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 132, Eff. Oct. 1, 2011;—Am. 2014, Act 51, Imd. Eff. Mar. 25, 2014.

Compiler's note: For transfer of certain powers and duties vested in the department of career development or its director, relating to powers and duties of state board of education or superintendent of public instruction to the department of labor and economic growth, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 280

400.57g Failure to comply with plan; penalties; "noncompliance" defined; notice; good cause; period of time recipient ineligible; denial or termination of benefits; "good cause" defined.

Sec. 57g. (1) Except as provided in subsection (5), if a recipient does not meet his or her individual family self-sufficiency plan requirements and is therefore noncompliant, the department shall impose the penalties described under this section. The department shall implement a schedule of penalties for instances of noncompliance as described in this subsection. The penalties shall be as follows:

(a) For the first instance of noncompliance, the family is ineligible to receive family independence program assistance for not less than 3 calendar months.

(b) For the second instance of noncompliance, the family is ineligible to receive family independence program assistance for not less than 6 calendar months.

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(c) For the third instance of noncompliance, the family is permanently ineligible to receive family independence program assistance.

(2) For the purposes of subsections (1) to (4), "noncompliance" means 1 or more of the following:

(a) A recipient quits a job.

(b) A recipient is fired for misconduct or absenteeism.

(c) A recipient voluntarily reduces employment hours or earnings.

(d) A recipient refuses a bona fide offer of employment or additional hours up to 40 hours per week.

(e) A recipient does not participate in PATH program activities.

(f) A recipient is noncompliant with his or her family self-sufficiency plan.

(g) A recipient states orally or in writing his or her intent not to comply with family independence program or PATH program requirements.

(h) A recipient refuses employment support services if the refusal prevents participation in an employment or self-sufficiency related activity.

(3) For any instance of noncompliance, the recipient shall receive notice of the noncompliance. The recipient shall have not less than a 12-day negative action period before the penalties prescribed in this section are imposed. If the recipient demonstrates good cause for the noncompliance during this period and if the family independence specialist caseworker and the PATH program caseworker agree that good cause exists for the recipient's noncompliance, a penalty shall not be imposed. For the purpose of this subsection, good cause is 1 or more of the following:

(a) The recipient suffers from a temporary debilitating illness or injury or an immediate family member has a debilitating illness or injury and the recipient is needed in the home to care for the family member.

(b) The recipient lacks child care as described in section 407(e)(2) of the personal responsibility and work opportunity reconciliation act of 1996, 42 USC 607.

(c) Either employment or training commuting time is more than 2 hours per day or is more than 3 hours per day when there are unique and compelling circumstances, such as a salary at least twice the applicable minimum wage or the job is the only available job placement within a 3-hour commute per day, not including the time necessary to transport a child to child care facilities.

(d) Transportation is not available to the recipient at a reasonable cost.

(e) The employment or participation involves illegal activities.

(f) The recipient is physically or mentally unfit to perform the job, as documented by medical evidence or by reliable information from other sources.

(g) The recipient is illegally discriminated against on the basis of age, race, disability, gender, color, national origin, or religious beliefs.

(h) Credible information or evidence establishes 1 or more unplanned or unexpected events or factors that reasonably could be expected to prevent, or significantly interfere with, the recipient's compliance with employment and training requirements.

(i) The recipient quit employment to obtain comparable employment.

(4) For all instances of noncompliance resulting in termination of family independence program assistance for any period of time described in subsection (1), the period of time the recipient is ineligible to receive family independence program assistance applies toward the recipient's 48-month cumulative lifetime total.

(5) Family independence program assistance benefits shall be denied or terminated if a recipient fails, without good cause, to comply with applicable child support requirements including efforts to establish paternity, and assign or obtain child support. The family independence program assistance group is ineligible for family independence program assistance for not less than 1 calendar month. After family independence program assistance has been terminated for not less than 1 calendar month, family independence program assistance may be restored if the noncompliant recipient complies with child support requirements including the action to establish paternity and obtain child support. As used in this subsection, "good cause" includes an instance in which efforts to establish paternity or assign or obtain child support would harm the child or in which there is danger of physical or emotional harm to the child or the recipient.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996;—Am. 2001, Act 280, Eff. Mar. 22, 2002;—Am. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2007, Act 9, Imd. Eff. May 18, 2007;—Am. 2011, Act 131, Eff. Oct. 1, 2011;—Am. 2014, Act 375, Eff. Jan. 1, 2016.

Popular name: Act 280

400.57h Repealed. 2011, Act 131, Eff. Oct. 1, 2011.

Compiler's note: The repealed section pertained to child care provider.

400.57i Rent vendoring program; certification by landlord that requirements met; violation of housing code; termination of participation; eviction prohibited; delinquency or

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nonpayment of property taxes.

Sec. 57i. (1) If a landlord or provider of housing participates in the department rent vendoring program, the landlord shall certify that the dwelling unit being provided meets all of the following requirements:

(a) The dwelling unit does not have a condition that would facilitate the spread of a communicable disease. As used in this subdivision, "communicable disease" means that term as defined in section 5101 of the public health code, 1978 PA 368, MCL 333.5101.

(b) The dwelling unit is fit for human habitation.

(c) The dwelling unit is not dangerous to life or health due to lack of repair of, a defect in, or the construction of a drainage source or device, plumbing, lighting, ventilation, or a heating source or device.

(2) If the department is notified by an enforcing agency that a landlord or provider of housing has a violation of a housing code that constitutes a hazard to the health or safety of the occupants, the department shall terminate that landlord's or provider's participation in the rent vendoring program for the dwelling unit until the violation is corrected.

(3) A landlord or provider of housing shall not evict an occupant from a dwelling unit based solely on termination of the landlord's or provider's participation in the rent vendoring program due to action taken by the department under subsection (2) or subsection (4). An occupant who is evicted in violation of this subsection may bring an action in any court having jurisdiction to recover treble damages, costs of the action, and reasonable attorney fees.

(4) If the department is notified that a landlord or provider of housing is delinquent on payment of property taxes or if the title of the property reverts to the state for nonpayment of property taxes, the department shall terminate that landlord's or provider of housing's participation in the rent vendoring program for that property.

History: Add. 2000, Act 478, Imd. Eff. Jan. 11, 2001;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57k Repealed. 2011, Act 131, Eff. Oct. 1, 2011.

Compiler's note: The repealed section pertained to individual account for postsecondary education, business capitalization, or first-time home purchase.

400.57*l* Feasibility of substance abuse testing program; report.

Sec. 57*l*. (1) The department shall review the feasibility of a substance abuse testing program within the family independence program. The department shall report the findings of a review under this section to the senate and house of representatives committees dealing with human services matters not later than December 1, 2011.

(2) The review conducted under and the report presented under subsection (1) shall include, at least, both of the following:

(a) The methods of substance abuse testing reviewed.

(b) The costs associated with the methods identified under subdivision (a).

History: Add. 1999, Act 17, Imd. Eff. Apr. 28, 1999;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57o Repealed. 2011, Act 131, Eff. Oct. 1, 2011.

Compiler's note: The repealed section pertained to study of impact and cost of increasing earned income that is disregarded to determine program group member's income for continued family independence assistance financial eligibility.

400.57p Counting certain months toward cumulative total of 48 months; exclusion.

Sec. 57p. Any month in which a recipient has been exempted from the JET program under section 57f(3) or (4)(b) shall not be counted toward the cumulative total of 48 months in a lifetime for family independence program assistance. Any month in which a recipient has been exempted from the JET program under section 57f(4)(e) or (f) may, in the department's discretion, be excluded from the count toward the cumulative total of 48 months in a lifetime for family independence program assistance.

History: Add. 2006, Act 471, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

400.57q Earned income disregard.

Sec. 57q. (1) Beginning October 1, 2011, upon the initial application for benefits for family independence program assistance, the department shall disregard $200.00 plus 20% of the family independence program assistance group's earned income for purposes of determining if the applicant's earned income exceeds the income and asset limits set by the department.

(2) Beginning October 1, 2011, the department shall disregard $200.00 plus 50% of the family

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independence program assistance group's earned income for the purpose of determining if the family independence program assistance group's income exceeds the income and asset limits set by the department throughout the duration of receiving family independence program assistance.

History: Add. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57r Family independence program assistance; limitation.

Sec. 57r. Beginning October 1, 2007, family independence program assistance shall be paid to an individual for not longer than a cumulative total of 48 months during that individual's lifetime.

History: Add. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2007, Act 9, Imd. Eff. May 18, 2007;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57s Repealed. 2015, Act 58, Eff. Oct. 1, 2015.

Compiler's note: The repealed section pertained to payment of $10.00 per month for 6 months for certain individuals.

400.57t Repealed. 2011, Act 131, Eff. Oct. 1, 2011.

Compiler's note: The repealed section pertained to implementation of JET program after September 30, 2007.

400.57u Reports.

Sec. 57u. (1) The department shall provide a report of exemptions under section 57f by district office and by criteria.

(2) The department shall provide a report by district office on the number of sanctions issued, the number of compliance exceptions granted, and the success rate of recipients given the compliance exception under section 57g.

(3) The department shall require district managers to track performance of caseworkers with regard to sanctions under section 57g.

(4) The department shall require reporting by county office on referrals to the medical review team and the following:

(a) Referrals pending less than 90 days.

(b) Referrals pending 90 to 180 days.

(c) Referrals pending 180 to 365 days.

(5) The department shall require a quarterly report on cases in which the recipient has applied for supplemental security income under section 57b as follows:

(a) The number of cases assessed.

(b) The number of cases referred to the JET program.

(c) The number of cases placed in subsidized employment.

(d) The number of cases referred to legal services advocacy programs and the number of cases granted supplemental security income.

(6) The department shall report the progress of the plan required under section 57q and its implementation progress annually by April 1.

(7) Except for the reporting requirement provided in subsection (6), all the reports required under this section shall be provided on a quarterly basis to all of the following:

(a) The senate and house standing committees dealing with appropriations for human services.

(b) The senate and house fiscal agencies.

(c) The majority leader of the senate and the speaker of the house of representatives.

History: Add. 2006, Act 468, Imd. Eff. Dec. 20, 2006;—Am. 2011, Act 131, Eff. Oct. 1, 2011.

Popular name: Act 280

400.57v Automatic teller machines located in casinos, casino enterprises, liquor stores, or adult entertainment establishments; blocking access to cash benefits from Michigan bridge cards; definitions.

Sec. 57v. (1) The department shall work with providers of automated teller machine services to create and implement a program or method of blocking access to cash benefits from Michigan bridge cards through point of sale devices and automated teller machines located in casinos, casino enterprises, liquor stores, or adult entertainment establishments.

(2) If the department requires a federal waiver to implement the provisions of this section, the department shall apply immediately upon enactment of this section for that federal waiver.

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(3) As used in this section:

(a) "Adult entertainment establishment" means any of the following:

(*i*) An on-premises licensee that holds a topless activity permit described in section 916(3) of the Michigan liquor control code of 1998, 1998 PA 58, MCL 436.1916.

(*ii*) Any other retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

(b) "Alcoholic liquor" means that term as defined in section 105 of the Michigan liquor control code of 1998, 1998 PA 58, MCL 436.1105.

(c) Subject to subsection (4), "casino" and "casino enterprise" mean those terms as defined in section 2 of the Michigan gaming control and revenue act, 1996 IL 1, MCL 432.202.

(d) "Gaming" means that term as defined in section 2 of the Michigan gaming control and revenue act, 1996 IL 1, MCL 432.202.

(e) "Liquor store" means a retailer as that term is defined in section 111 of the Michigan liquor control code of 1998, 1998 PA 58, MCL 436.1111, that is exclusively or primarily engaged in the sale of alcoholic liquor. For the purpose of this section only, a retailer does not include a retail food store.

(f) "Retail food store" means that term as defined in 7 USC 2012.

(4) As used in this section, the terms casino and casino enterprise do not include any of the following:

(a) A grocery store that sells groceries, including staple foods, and is located in a casino or a casino enterprise.

(b) Any other business establishment that offers gaming that is incidental to the principal purpose of that establishment.

History: Add. 2012, Act 197, Imd. Eff. June 26, 2012;—Am. 2013, Act 194, Eff. Feb. 1, 2014.

Popular name: Act 280

400.57y Suspicion-based substance abuse screening and testing; pilot program; use of empirically validated substance abuse screening tool; requirement that applicant or recipient take substance abuse test; refusal; cost of administering test.

Sec. 57y. (1) The department shall establish and administer a program of suspicion-based substance abuse screening and testing for family independence program applicants and recipients as described in this section and section 57z.

(2) Subject to state appropriation, the department shall, in accordance with section 14g, administer a suspicion-based substance abuse screening and testing pilot program for family independence program applicants and recipients in 3 or more counties in this state. The department shall determine which 3 or more counties shall begin the initial administration of the suspicion-based substance abuse screening and testing required in this subsection.

(3) Upon initial application and at annual redetermination, the department shall screen family independence program applicants and recipients for suspicion of substance abuse using an empirically validated substance abuse screening tool.

(4) If the results of the substance abuse screening gives the department a reasonable suspicion to believe that the applicant or recipient has engaged in the use of a controlled substance, the applicant or recipient is required to take a substance abuse test.

(5) If the applicant or recipient refuses to take a substance abuse test, he or she is ineligible for family independence program assistance, but may reapply after 6 months. If the applicant or recipient reapplies for family independence program assistance, he or she must test negative for use of a controlled substance.

(6) If the applicant or recipient tests negative for use of a controlled substance, the cost of administering the substance abuse test to him or her shall be paid for by the department.

History: Add. 2014, Act 394, Eff. Mar. 31, 2015.

Popular name: Act 280

400.57z First positive test for use of controlled substance; referral to department-designated community mental health entity; second or subsequent positive test for use of controlled substance; applicant or recipient ineligible for assistance; time period for pilot program; report; age of applicant or recipient; definitions.

Sec. 57z. (1) If an applicant or recipient tests positive for use of a controlled substance and it is the first time that he or she tested positive for use of a controlled substance under the pilot program described in this section and section 57y, the department shall refer the individual to a department-designated community mental health entity and, if he or she is otherwise eligible, provide or continue to provide family independence

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program assistance to him or her. For an applicant described in this subsection, the cost of administering the substance abuse test to him or her shall be deducted from his or her first family independence program assistance payment. For a recipient described in this subsection, the cost of administering the substance abuse test to him or her shall be deducted from his or her first family independence program assistance payment after the redetermination. If the applicant or recipient described in this subsection fails to participate in treatment offered by the department-designated community mental health entity or fails to submit to periodic substance abuse testing required by the department-designated community mental health entity, the department shall terminate his or her family independence program assistance.

(2) If an applicant or recipient tests positive for use of a controlled substance and it is the second or subsequent time that he or she tested positive for use of a controlled substance under the pilot program described in this section and section 57y, he or she is ineligible for family independence program assistance. If the applicant or recipient reapplies for family independence program assistance, he or she must test negative for use of a controlled substance in order to receive family independence program assistance. The department may provide a referral to the applicant or recipient to a department-designated community mental health entity for substance abuse treatment.

(3) The pilot program described in this section and section 57y shall begin not later than October 1, 2015 and conclude not later than September 30, 2016 but shall last not less than 1 year.

(4) Not later than 60 days after the conclusion of the pilot program described in this section and section 57y, the department shall submit a report to the legislature that includes, at least, all of the following:

(a) The number of individuals screened.

(b) The number of individuals screened for whom there was a reasonable suspicion of use of a controlled substance.

(c) The number of individuals who consented to submitting to a substance abuse test.

(d) The number of individuals who refused to submit to a substance abuse test.

(e) The number of individuals who submitted to a substance abuse test who tested positive for use of a controlled substance.

(f) The number of individuals who submitted to a substance abuse test who tested negative for use of a controlled substance.

(g) The number of individuals who tested positive for use of a controlled substance a second or subsequent time.

(h) The amount of the costs incurred by the department for administering the program.

(i) The number of applicants and recipients who were referred to a department-designated community mental health entity under this section.

(j) Sanctions, if any, that have been imposed on recipients as a result of the substance abuse testing under this section.

(5) For the purposes of this section and section 57y only, an applicant or recipient is an individual who is 18 years of age or older.

(6) For purposes of this section and section 57y only, "use of a controlled substance" does not include a recipient or applicant who has a prescription for the controlled substance from a treating physician or a recipient or applicant who tests positive for marihuana if the recipient or applicant is a qualifying patient who has been issued and possesses a registry identification card according to the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430.

(7) As used in this section and section 57y, "controlled substance" means that term as defined in section 7104 of the public health code, 1978 PA 368, MCL 333.7104.

(8) As used in this section:

(a) "Department-designated community mental health entity" means that term as defined in section 100a of the mental health code, 1974 PA 258, MCL 330.1100a.

(b) "Qualifying patient" and "registry identification card" mean those terms as defined in section 3 of the Michigan medical marihuana act, 2008 IL 1, MCL 333.26423.

History: Add. 2014, Act 395, Eff. Mar. 31, 2015.

Popular name: Act 280

400.58 County medical care facility; program of care and treatment; medical treatment and nursing care; special treatment; building; review of proposals and plans; inspection; enforcement.

Sec. 58. (1) A county board may, with the approval of the county board of commissioners, supervise and be responsible for the operation of a county medical care facility in, auxiliary to, or independent of the county infirmary. If a county has a board of county institutions, a county medical care facility shall be supervised and

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operated by the board of county institutions, and all references in this section to the county board means, for that county, the board of county institutions. The county board in a county that has established a county medical care facility may collect from any available source for the cost of care given in the facility and the collections shall be deposited in the social welfare fund created under section 73a. The facility shall provide a program of planned and continuing medical treatment and nursing care under the general direction and supervision of a licensed physician employed full or part-time who shall be known as the medical director.

(2) Medical treatment and nursing care provided in a county medical care facility shall consist of services given to persons suffering from prolonged illness, defect, infirmity, or senility, or recovering from injury or illness. The services provided shall include some or all of the procedures commonly employed, such as physical examination, diagnosis, minor surgical treatment, administration of medicines, providing special diets, giving bedside care, and carrying out any required treatment prescribed by a licensed physician that are within the ability of the facility to provide.

(3) Services provided in a county medical care facility shall be consistent with the needs of the type of patient admitted and cared for, professionally supervised and planned, and provided on a continuing basis. A person shall not be admitted or retained for care if he or she requires special medical or surgical treatment or treatment for a psychosis, tuberculosis, or contagious disease, except that the facility may contain a supervised psychiatric ward for the temporary detention of mentally ill patients if the ward has been inspected and approved by the department of community health and certified by the department of community health to the county board, and if no other facility for temporary detention of mentally ill patients exists in the county. A county department may provide for the support of poor persons who may be feeble-minded or mentally ill at some other place or places and in a manner that best promotes the interests of the county and the comfort and recovery of such persons, at the expense of the county.

(4) A county board, in seeking approval to establish, extend, and operate a county medical care facility in an existing building, shall apply in writing to the department. The county board shall include with the application a proposed plan with specifications, including standards of operation, for the examination and recommendations of the department.

(5) A county board of commissioners may determine to erect a county infirmary or county medical care facilities for the reception and care of the poor and unfortunate of the county. The county medical care facilities may be on different sites than the county infirmary. On filing the determination with the county clerk, the county board of commissioners may direct the county board to purchase 1 or more tracts of land, not exceeding 320 acres, and to erect on the land 1 or more suitable buildings for the county infirmary or county medical care facilities. Before any county infirmary or county medical care facility is erected or any existing buildings are remodeled, added to, or substantially altered under this section, before plans for the county infirmary or county medical care facilities are finally accepted, and before any contract is entered into for construction, the plans shall be submitted to the department for examination and approval. The determination reached shall be certified to the county clerk and presented to the county board of commissioners at the next regular meeting of the county board of commissioners. A county infirmary or county medical care facility shall not be constructed unless the plans have been certified under this subsection. A contract for the erection of a county infirmary or county medical care facility is not valid or binding unless the plans referred to in the contract and actually followed in the construction have been approved. Money shall not be paid from county funds for construction until the plans have been approved and the determination filed.

(6) The department shall review the proposals and plans of a county board submitted in connection with an application for the establishment, extension, and operation of a county medical care facility or county infirmary and shall consult with and give advice to the county department as to plans, procedures, and programs required for the proper establishment, extension, and operation of the county medical care facility or county infirmary.

(7) The department shall approve the county medical care facilities by proper notice to the county department. After approval, the department shall inspect the facility as frequently as it considers necessary, but at least once each year. A county department shall comply with any reasonable order issued by the department. The county department may appeal an order in writing, within 30 days of receiving the order, to the director of the department.

(8) Any reasonable order of the department for the establishment, extension, operation, or closing of a county infirmary or county medical care facility may be enforced by mandamus or injunction in the circuit court for the county where the facility is located in proceedings instituted by the attorney general on behalf of the department.

(9) A county medical care facility shall not be opened for operation until it has been inspected and approved in writing to the department by the bureau of fire services created in section 1b of the fire protection

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code, 1941 PA 207, MCL 29.1b, and the department of community health. The county department shall comply with any reasonable directive issued by the bureau of fire services or the department of community health with regard to the fire safety and sanitation of the county infirmary or county medical care facility. A directive may be enforced by the department in the same manner as are orders of the department. After receiving the approval of the department, the county department shall represent the facility to the public as the county medical care facility and shall make reasonable and continuing effort to divorce the facility from an association in the public mind with the words "poor house" or "poor farm".

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.58;—Am. 1954, Act 125, Eff. Aug. 13, 1954;—Am. 1957, Act 170, Eff. Sept. 27, 1957;—Am. 2006, Act 200, Imd. Eff. June 19, 2006.

Compiler's note: For transfer of powers and duties of state fire marshal to department of labor and economic growth, bureau of construction codes and fire safety, by type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 280

400.58a County medical care facility; admittance.

Sec. 58a. Only those persons may be admitted to the county medical care facility who require the individualized medical care, treatment and supervision provided by the facility and who do not require major surgery, treatment for psychosis, treatment for tuberculosis, contagious disease or other specialized hospital care. The facility is designed to care especially for persons, otherwise eligible for admission, who are 65 years of age or older, including persons who evidence the general manifestations of senility without the presence of a psychosis and the need of treatment therefor; or who, being of lesser age, are blind, chronically ill or disabled: Provided, That the provisions of this amendatory act with respect to special medical or surgical treatment shall not apply to those counties where such medical or surgical treatment is being provided on the effective date of this act.

History: Add. 1954, Act 125, Eff. Aug. 13, 1954.

Popular name: Act 280

400.58b County medical care facility; eligibility for care; state aid recipient; admission of patients; state and federal aid for capital expenditures; special tax.

Sec. 58b. The state department in accordance with its rules and regulations may pay for medical care that a recipient of aid to the blind, aid to disabled, aid to dependent children, or old age assistance, receives in the county medical care facility. Other persons admitted to care in the facility shall be charged for the cost of their care to the extent of their financial ability as determined by the county department and such financial ability shall not preclude their eligibility for such care. Prior consideration shall be given to any person who comes within the definition of a “poor person” set forth in section 1 of chapter 1 of Act No. 146 of the Public Acts of 1925, as amended, being section 401.1 of the Compiled Laws of 1948. No poor persons as so defined shall be refused admittance to a county medical care facility if there are then within such county medical care facility persons who are not senile and who are paying the total cost of their care.

Any county department which shall accept state financial aid for capital expenditures related to the establishment, extension or improvement of its facilities shall accept for care any patient eligible for admission as provided in section 58a, and having a domicile in the county and any patient for whom care is requested by the state department because of being found in the county without either a known domicile in the state or a place of residence outside the state to which he may be returned.

Direct state financial aid to meet part of the cost of capital expenditures for the establishment, extension or improvement of a county medical care facility may be provided from the general funds of the state or from such federal funds as may be made available in the following manner: The county social welfare board with the approval of the county board of supervisors will make an application to the state department as otherwise provided in section 58 but shall make in addition, a showing of need, in the same manner as provided in section 18, that it is unable to meet all of the capital expenses of a county medical care facility. The state department shall determine the percentage of the total capital cost of the facility which the county will be unable to meet and shall request from the legislature an appropriation from the general fund of the state or such federal funds as may be made available for this purpose to meet this amount. Requests of the legislature from the state department for such appropriations shall be separate items for each medical care facility. The amount of state aid actually granted the county by the state department shall not exceed (1) the amount appropriated by the legislature in respect to the amount of the item in the budget, or (2) the percentage of state aid required as previously determined by the state department, whichever is the lesser.

To defray the cost of construction in the establishment or extension of the medical care facility, the board of supervisors may raise in any 1 year a sum not exceeding .1 mill of each dollar of assessed valuation of the county, such tax to be regarded as a special tax collected in the same manner as other county charges, and

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moneys received therefrom shall be transmitted to the treasurer of the county who shall deposit same in a special fund to be used solely for the purposes for which the tax is spread. Money expended for construction in the establishment or extension of the facility shall be paid out by the county treasurer on the order of the county social welfare board.

History: Add. 1954, Act 125, Eff. Aug. 13, 1954;—Am. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961;—Am. 1965, Act 221, Imd. Eff. July 16, 1965;—Am. 1966, Act 228, Eff. Aug. 1, 1966.

Popular name: Act 280

400.58c County medical care facility; patients with contagious disease, isolation.

Sec. 58c. Notwithstanding any other provision of this act, patients suffering from contagious diseases may be admitted to any county medical care facility where the facility is constructed or operated with the approval of the state department of social welfare and is able to provide an isolated area for such care approved by the state health commissioner.

History: Add. 1961, Act 176, Eff. Sept. 8, 1961.

Popular name: Act 280

400.59 Applications for aid, relief or assistance; forms, ascertainment of settlement, charge to county of domicile; temporary relief to persons with no settlement.

Sec. 59. All applications for aid, relief or assistance provided under this act shall be made to the county department of social welfare in such manner and upon such forms as may be prescribed by the state department. When any person applies for or requires public aid as a poor person under this act other than hospitalization or those forms of aid financed in whole or in part by federal funds, the county department shall ascertain the legal settlement and domicile of the person. The county department shall ascertain the settlement and domicile of other persons when requested by the county health department or by the state health commissioner. Except as otherwise provided in this act, general relief granted to persons with a legal settlement in this state may be charged to the county of domicile. The sending of notices, billings and appeals in respect to charges to the county of domicile, shall be made in accordance with regulations of the commission. Wherever in this act a chargeback or return to the county or city of "settlement" or "legal settlement" is authorized a chargeback or return to the county or city of "domicile" shall be deemed to be intended. Hospitals, jails, nursing homes, convalescent homes, homes for the aged and prisons are not places of domicile. General relief and hospitalization granted to persons who, while receiving assistance under this act, move into a county to receive care in a home for the aged, convalescent home or other institution shall be a charge against the county of their domicile just prior to the move regardless of other provisions of this act and even though domicile in the home for the aged or other institutions is intended. Temporary relief granted to persons with no settlement in this state shall be at the expense of the county where found. In the case of persons illegally brought or induced to come into the county, necessary relief shall be a charge against the county where they were living when transported or induced to move.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.59;—Am. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.59a Return of person to county of residence; deportation to another nation; expense; reimbursement from county of residence.

Sec. 59a. The county or city department of social welfare, as part of its general relief program, may provide funds and necessary attendants for the return of a person to his place of residence as authorized in section 55, or to a new place of residence under the conditions of sections 59 or 59f. State or county funds shall not be used for the return of a person to another nation who may be deported under federal law.

If the probable place of legal settlement is in Michigan and the probable place of domicile is in some other county of this state, the county department where application for aid was made, within 60 calendar days following the application, shall give notice and necessary information in writing to the county department of the county of probable domicile on forms prescribed for that purpose by the state department. If it appears that domicile may lie in any 1 of 2 or more counties notices shall be sent to all such counties. If the notice is not given to the county of probable domicile within 60 days following the application for aid, the county granting relief to the applicant shall have no claim whatsoever irrespective of any other provisions of this act, for reimbursement for the relief granted the applicant prior to 60 calendar days preceding the date the notice is given to the county of probable domicile.

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History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.59b Notification of county of residence; denial of settlement, notice.

Sec. 59b. Counties receiving notices shall acknowledge their receipt and within 60 calendar days thereafter shall make an investigation of the case and acknowledge that settlement lies in Michigan and domicile within the county or present to the county department granting relief detailed evidence, together with and supporting a denial of the settlement or domicile or both. If the county department receiving a denial is not satisfied with the evidence supporting it, appeal may be made to the director of the state department. If the notice of denial is not given to the county department granting relief within 60 calendar days after the county of probable domicile receives notice, the county department granting relief, irrespective of any other provisions of this act, shall be reimbursed by the county receiving the notice for all relief granted the applicant prior to the date the notice of denial is given. In the case of 2 or more counties having received notices under section 59a and none having acknowledged settlement and domicile, the failure to acknowledge may be treated as a denial for the purpose of an appeal to the director.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961.

Popular name: Act 280

400.59c Domicile and legal settlement cases; appeal, determination by state department.

Sec. 59c. Upon receiving an appeal, the director shall set a time and place for a hearing and designate an employee of the state department to serve as referee at the hearing. If the appealing county waives its right to a personal appearance at the hearing, the notice to the denying county shall so state and the denying county shall decide whether or not to do likewise. If it so decides, the designated referee shall advise the director of the department as to his findings in respect to settlement and domicile from written evidence submitted by the contending counties.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961.

Popular name: Act 280

400.59d Domicile and legal settlement cases; appeal; insufficient evidence.

Sec. 59d. The decision of the director may be in favor of either of the contending counties or that domicile lies in neither of the counties or that settlement does not lie in this state or that there is insufficient evidence on which to make a finding of settlement. The decision of the director shall be final. If the decision is that there is insufficient evidence for a determination, all the proceedings of both counties shall be set aside and the county granting relief may proceed anew as if no notice had been sent under sections 59a and 59b.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961.

Popular name: Act 280

400.59e Domicile and legal settlement cases; notices, evidence, bills for aid; rules and regulations.

Sec. 59e. The state department shall make suitable rules and regulations governing the sending and form of notices and evidence in domicile and legal settlement cases, and the sending of bills for aid granted as provided in section 68a of this act, to insure prompt and economical administration of the accounting for and collection of the aid granted. When settlement is found in this state and the county of domicile is finally determined by the director of the state department to be some county other than the initiating county, the county of domicile shall be charged for all aid granted in accordance with law by the county department where application was made during the 1 year preceding the date of determination.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961.

Popular name: Act 280

400.59f Joint plan for economic rehabilitation of aid recipient; removal from county of settlement.

Sec. 59f. The county department of the county of domicile or the county department granting aid may request joint planning with another county department if it appears to the requesting county that the person receiving aid should remove to or remain in the other county. The joint plan shall consider the relative possibilities of economic rehabilitation of the person in each of the 2 counties but if these appear approximately equal, the departments shall consult the wishes of the person. If, as the result of the joint planning, the 2 county departments determine that a person should be removed, the plan shall be presented to

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the person who will be informed that as soon as a suitable living arrangement can be made in the other county, he will be removed. If he declines to accept the plan, aid shall not be continued. He may re-apply for aid after 30 days.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961.

Popular name: Act 280

400.59g Joint plan for economic rehabilitation of aid recipient; disagreement, appeal to director.

Sec. 59g. (1) If the 2 counties concerned find themselves unable to agree on a joint plan, either may appeal to the director of the state department to make a determination of which plan is most in the public interest in the case. The director shall have the same power and shall proceed to act on such appeals in the same manner as on appeals under sections 59c, 59d and 59e of this act.

(2) If the plan so determined provides that the person shall continue to live in the county granting relief, the relief shall be granted at the expense of that county.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961.

Popular name: Act 280

400.60 Fraudulent device to obtain relief; liability; misdemeanor; penalty; information to be provided by recipients.

Sec. 60. (1) Any person who by means of willful false statement or representation, by impersonation or other fraudulent device, or by using an access device obtains or attempts to obtain, or aids or abets any person to obtain or attempt to obtain, (a) assistance or relief to which the person is not entitled; or (b) a larger amount of assistance or relief than that to which the person is justly entitled; or any officer or employee of a county, city, or district family independence agency who authorizes or recommends relief to persons known to the officer or employee to be ineligible or to have fraudulently created their eligibility; or any person who knowingly buys or aids or abets in buying or in disposal of the property of a person receiving assistance or relief without the consent of the director or supervisor of the state department shall, if the amount involved shall be of the value of $500.00 or less, be deemed guilty of a misdemeanor and shall, if the amount involved shall be of the value of more than $500.00, be deemed guilty of a felony, and upon conviction shall be punished as provided by the laws of this state. The amount involved as used in this subsection shall be defined as the difference between the lawful amount of assistance or aid and the amount of assistance or aid actually received. If anyone receives assistance or relief through means enumerated in this section, in which prosecution is deemed unnecessary, the state department or county departments may take the necessary steps to recover from the recipient the amount involved, plus interest at 5% per annum. On conviction of the violation of the provisions of this section of any officer or employee of any county, city, or district department of social welfare, the officer or employee shall be removed or dismissed from office. For the purpose of this subsection, “access device” means that term as it is defined in section 300a of the Michigan penal code, 1931 PA 328, MCL 750.300a.

(2) There is imposed upon every person receiving relief under this act either upon the person's own application or by the person's inclusion, to his or her knowledge, in the application of another the continuing obligation to supply to the department issuing the relief: (a) the complete circumstances in regard to the person's income from employment or from any other source or the existence of income, if known to the person, of other persons receiving relief through the same application; (b) information regarding each and every offer of employment for the person or, if known to him or her, of the other persons receiving relief through the same application; (c) information concerning changes in the person's circumstances or those of other persons receiving relief through the same application which would decrease the need for relief; and (d) the circumstances or whereabouts, known to the person, of relatives legally responsible for the person's support or for the support of other persons receiving relief through the same application if changes in those circumstances or whereabouts could affect the amount of assistance available from those relatives or affect their legal liability to furnish support. Any person who shall neglect or refuse to submit to the department issuing relief the information required by this section, if the amount of relief granted as a result of the neglect or refusal is less than $500.00, is guilty of a misdemeanor, and if the amount of relief granted as a result of the neglect or refusal is $500.00 or more, is guilty of a felony, and upon conviction shall be punished as provided by the laws of this state.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.60;—Am. 1950, Ex. Sess., Act 18, Eff. Mar. 31, 1951;—Am. 1969, Act 179, Imd. Eff. Aug. 5, 1969;—Am. 1999, Act 194, Imd. Eff. Dec. 1, 1999.

Popular name: Act 280

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400.60a Program of computer data matching; development and implementation; report.

Sec. 60a. (1) The department shall develop and implement a program of computer data matching by which the department shall compare its computer records concerning applicants for, and recipients of, assistance under this act with the computer records of financial institutions, to determine if the applicants or recipients have assets or income in excess of the eligibility limits established by the state department for assistance under this act.

(2) Not later than May 1, 1986, the state department shall report to the chairpersons of the house and senate committees primarily responsible for legislation concerning social services and the chairpersons of the house and senate appropriations committees. The report shall describe the state department's implementation of this section and shall include a summary of the results of the computer data matching program.

History: Add. 1985, Act 140, Imd. Eff. Oct. 28, 1985.

Popular name: Act 280

400.61 Violations; penalties; cessation of payments during imprisonment.

Sec. 61. (1) Except as provided in subsections (2) and (3), a person who violates this act for which a penalty is not specifically provided is guilty of a misdemeanor and, upon conviction, shall be sentenced as provided in the laws of this state. If a person receiving aid, relief, or assistance is convicted of an offense under this act, or of another crime or offense and punished by imprisonment for 1 month or longer, the county board may direct that payments for aid, relief, or assistance under this act shall cease and shall not be made during the period of that person's imprisonment.

(2) A member of the Michigan social welfare commission, a county social services board, or the parole and review board who intentionally violates section 2(3), 46(2), or 121(2), shall be subject to the penalties prescribed in Act No. 267 of the Public Acts of 1976.

(3) If the Michigan social welfare commission, a county department of social services, a county social services board, district department of social welfare, district social welfare board, or the parole and review board arbitrarily and capriciously violates section 2(6), 45(6), 46(6), or 64(3) the commission, department, or board shall be subject to the penalties prescribed in Act No. 442 of the Public Acts of 1976.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.61;—Am. 1978, Act 224, Imd. Eff. June 13, 1978.

Popular name: Act 280

400.62 Relief or assistance; effect of amendment or repeal; no claim for compensation.

Sec. 62. All aid and relief granted under this act shall be deemed to be granted and to be held subject to the provisions of any amending or repealing act that may hereafter be passed, and no recipient thereof shall have any claim for compensation, or otherwise, by reason of his aid or relief being affected in any way by any amending or repealing act.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.62.

Popular name: Act 280

400.63 Aid, relief, or assistance; nonassignability; breach of lease agreement; conveyance of amount to judgment creditor; federal waiver; processing fee; biennial report; "recipient" defined.

Sec. 63. (1) Except as provided in subsection (2), all aid, relief, or assistance given under this act is absolutely inalienable by any assignment, sale, garnishment, execution, or otherwise, and in the event of bankruptcy, shall not pass to or through any trustee or other person acting on behalf of creditors.

(2) To the extent allowed by law, if a judgment is entered against a recipient for damages arising from the recipient's breach of an oral or written lease agreement for rental housing and the judgment creditor submits a certified copy of the judgment to the department, the department shall deduct up to 10% of each cash grant for which the department determines the recipient is eligible and convey that amount to the judgment creditor until the judgment is satisfied. This subsection applies only to a lease agreement for property that has not been found to be in violation of an applicable housing code by a state or local agency authorized to enforce housing laws. This subsection does not create a cause of action against the department for damages caused by a recipient's breach of a lease agreement.

(3) If a federal waiver is necessary to implement subsection (2), the department shall promptly seek the waiver. In the absence of a necessary waiver, the department shall apply this section only to recipients of assistance programs financed entirely by state or local revenues.

(4) The judgment creditor shall pay a $1.00 processing fee to the department for each payment made under subsection (2). The department may deduct the processing fee from each payment made to the judgment

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creditor.

(5) The department shall include in its biennial report required under section 17 the number of cases and the dollar amounts deducted under subsection (2). The report shall include statewide totals and information broken down by county.

(6) As used in this section, "recipient" means an individual receiving direct cash assistance under this act.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.63;—Am. 1995, Act 235, Eff. Mar. 28, 1996.

Popular name: Act 280

400.63a Contract awards to specific organizations.

Sec. 63a. The family independence agency shall not award contracts to specific organizations that have not been competitively bid unless the award is permissible under state contracting procedures.

History: Add. 1995, Act 223, Eff. Mar. 28, 1996.

Popular name: Act 280

400.64 Applications and records considered public records; inspection; public access; restriction; uttering, publishing, or using names, addresses, or other information; confidentiality; alphabetical index file; inquiry as to name or amount of assistance; making available certain information to public utility or municipality; disclosure of information; violation; penalty; notice of assistance to deserted or abandoned child; documents, reports, or records from another agency or organization.

Sec. 64. (1) Notwithstanding sections 2(6), 35, 45(6), and 46(6), applications and records concerning an applicant for or recipient of assistance under the terms of this act, except medical assistance, are public records and are open to inspection by persons authorized by the federal or state government, the state department, or the officials of the county, city, or district involved, in connection with their official acts and by the general public as to the names of recipients and the amounts of assistance granted. General public access is restricted to persons who present a signed application containing the name, the address, and the occupation of the persons signing the application. A person shall not utter or publish the names, addresses, or other information regarding applicants or recipients except in cases where fraud is charged or wrongful grant of assistance is alleged. A person shall not use the names, addresses, or other information regarding applicants or recipients for political or commercial purposes.

(2) Records relating to persons applying for, receiving or formerly receiving medical services under the categorical assistance programs of this act are confidential and shall be used only for purposes directly and specifically related to the administration of the medical program.

(3) In each county, the department shall maintain an alphabetical index file in its office of cases receiving assistance through the department. When a citizen makes a personal visit to an office during regular office hours, and makes inquiry as to the name or amount of assistance being received by a person, the requester shall be given the information requested in the manner prescribed by the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(4) Subject to restrictions prescribed by federal regulations governing temporary assistance for needy families or other federal programs, rules of the state department, or otherwise, for preventing the disclosure of confidential information to any person not authorized by law to receive the confidential information, the state department shall make available to a public utility regulated by the Michigan public service commission or a municipality information concerning applicants for, and recipients of, public assistance, the disclosure of which is necessary and the use of which is strictly limited to the purpose of a public utility's administering a program created by statute or by order of the Michigan public service commission and intended to assist applicants for, or recipients of, public assistance in defraying their energy costs.

(5) The state department may disclose information regarding applicants for, and recipients of, assistance under this act in connection with the administration of assistance under this act, including the implementation and administration of section 60a, to the extent that the disclosure in regard to applicants for and recipients of federally funded assistance is in accordance with applicable federal law and regulations regarding disclosure of confidential information concerning applicants for or recipients of federally funded assistance.

(6) Except as prescribed in section 61(2) and 61(3), a person who violates this section is, upon conviction, guilty of a misdemeanor punishable by imprisonment for not more than 2 years or by a fine of not more than $1,000.00, or both. If an employee of the state violates this section, the employee is also subject to dismissal from state employment subject to rules as established by the civil service commission.

(7) The county department shall give prompt notice to appropriate law enforcement officials of the furnishing of temporary assistance for needy families in each case where a child has been deserted or

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abandoned by a parent and assistance is being furnished to the child.

(8) Documents, reports, or records authored by or obtained from another agency or organization shall not be released or open for inspection under subsection (1) unless required by other state or federal law, in response to an order issued by a judge, magistrate, or other authorized judicial officer.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.64;—Am. 1952, Act 267, Eff. Sept. 18, 1952;—Am. 1953, Act 197, Eff. Oct. 2, 1953;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1968, Act 169, Imd. Eff. Jan. 17, 1968;—Am. 1978, Act 224, Imd. Eff. June 13, 1978;—Am. 1978, Act 576, Imd. Eff. Jan. 2, 1979;—Am. 1984, Act 26, Eff. Apr. 12, 1984;—Am. 1985, Act 140, Imd. Eff. Oct. 28, 1985;—Am. 2014, Act 528, Eff. Mar. 31, 2015.

Popular name: Act 280

400.65 Hearings within county department; rules for procedure; review by board.

Sec. 65. The board shall prescribe rules and regulations for the conduct of hearings within the county department, and provide adequate procedure for a fair hearing of appeals and complaints by any applicant for or recipient of aid, relief, or assistance under the jurisdiction of the board. Such hearing may be conducted by the director or by any agent designated by him, but shall be subject to a review by the board, upon filing of a request in writing.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.65;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.66 Finality of decision as to relief or medical care; investigation by department.

Sec. 66. As to those forms of relief which are in no part financed by state or federal funds, the decision of the county or district department of social services as to the denial, granting, form, and amount of that relief shall be final, except as provided in section 66i. In a county that establishes a patient care management system under section 66j, the decision of the county as to the denial, granting, form, and amount of medical care shall be final. This section does not prevent the state department from making investigations, collecting statistics, and otherwise gaining information concerning the administration of welfare in any county or district as the state department considers advisable.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.66;—Am. 1962, Act 195, Imd. Eff. June 4, 1962;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965;—Am. 1975, Act 237, Eff. Dec. 1, 1975;—Am. 1979, Act 216, Eff. Oct. 1, 1980;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66a Hospitalization for recipient; rules of financial eligibility; reimbursement; "hospitalization" defined; filing agreement, statement, or schedule of charges; report of treatment; statement of expenses; charges for special nurses; expenses after discharge.

Sec. 66a. The county social welfare boards shall make provision for hospitalization which is necessary and not more advantageously provided to the recipient under other law or provided under other sections of this act for every person found in their respective counties under rules of financial eligibility established by the boards and shall be reimbursed 100% by the state for the monthly net cost of the hospitalization for nonresidents of the state. The county department, in its discretion, may direct that the patient be conveyed to the university hospital at Ann Arbor or any other hospital for hospitalization. As used in this act, "hospitalization" means medical, surgical, or obstetrical care in the university hospital or in a hospital licensed under article 17 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.20101 to 333.22190 of the Michigan Compiled Laws, together with necessary drugs, x-rays, physical therapy, prosthesis, transportation, and nursing care incidental to the medical, surgical, or obstetrical care, but shall not include medical care as defined in section 55. Before a patient shall be admitted except in an emergency, to any hospital other than the university hospital, a definite agreement, statement, or schedule of charges, expenses, and fees to be received by the hospital and physicians or surgeons performing necessary services under this act shall be filed with the county department of the county in which the hospital is located and approved by the county department, except as provided for in section 66i. The hospital shall, at the conclusion of the treatment, make a report of the treatment and an itemized statement of the expenses of the treatment to the county department which issued the order, but charges for special nurses shall not be made without the consent of the county social welfare director. The expenses for sending the patient home or to other institutions after being discharged from the hospital may be paid by the hospital and charged in the regular bill for maintenance unless different instructions have been received from the county department which issued the order for admission.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1979, Act 216, Eff. Oct. 1, 1980.

Popular name: Act 280

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400.66b Hospitalization; application; emergency care, intercounty payments; arbitration of payment disputes.

Sec. 66b. The county social welfare board shall require the county department to act promptly on all applications for hospitalization and shall provide for retroactive authorizations for emergency care in accordance with rules which the board shall establish including one defining "emergency". When the person hospitalized in an emergency is found to be eligible for hospitalization at public expense under section 66a of this act and is found to be a transient in the county with a domicile elsewhere in the state, the county in which his domicile is located shall be responsible for the cost of hospitalization to the county department which has authorized the care. When a patient is taken without authorization in an emergency across a county line to a hospital in a county other than the county of domicile of the patient, the county department in which the emergency occurred shall be responsible, in accordance with its own rules governing emergency care, to the hospital for the expense of the emergency care subject to reimbursement by the county of domicile as provided by this section. The state department shall provide rules governing intercounty payments and shall arbitrate and decide disputes arising thereunder.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957.

Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.66c Hospitalization; reimbursement of county expense.

Sec. 66c. The county department shall enter into an agreement signed by the patient or a legally responsible relative or guardian for reimbursement of the net cost to the county in furnishing such hospitalization: Provided, That such an agreement between the patient and the county department shall be deemed to be in existence in respect to an emergency hospitalization. The spouse, parent and adult child or any such patient being of sufficient ability shall be jointly and severally liable to the county department for the reimbursement of the expenses incurred by the county in furnishing such hospitalization to the extent that such expenses are not reimbursed from another source. Such liability may be enforced in an action at law.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957.

Popular name: Act 280

400.66d Finality of determination of ineligibility for hospitalization.

Sec. 66d. The determination that a person is ineligible for hospitalization under section 66a or 66j made by the county responsible for care shall be final.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66e Receipt of authorized patients by university hospital; duties of admitting officer; treatment; compensation; insurance; affidavit of expenses; report on condition of patient and expense incurred.

Sec. 66e. The admitting officer of the university hospital, upon receiving a patient with an authorization issued by a county department of social services under this act, may provide a bed in the hospital and designate the clinic of the hospital to which such person shall be assigned for treatment. The physician or surgeon in charge of the patient shall proceed with proper care to perform such operation and bestow such treatment upon the patient as in his judgment shall be necessary. No compensation shall be charged or received by the admitting officer, or by the medical faculty or by the physician, surgeon or nurses of the university hospital who shall treat and care for the patients, other than the salaries received by them provided by the board of regents of the university. If any such patient has medical or surgical insurance coverage the university hospital may then charge for the service of its medical and surgical staff in amounts not to exceed the amounts available from such insurance coverage. The superintendent shall make and file with the county board of social services an affidavit containing so far as possible an itemized statement of all expenses of hospitalization incurred at said hospital in care of patients admitted under this act in accordance with the usual rates therefor fixed by the regents of the university. He shall also make reports at suitable intervals to the county department which issued the order, stating the condition of the patient and the expense incurred. No county shall be liable for expenses incurred after the expiration date of the order of the county department unless a new order is obtained.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1971, Act 146, Imd. Eff. Nov. 12, 1971.

Popular name: Act 280

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400.66f Repealed. 1971, Act 146, Imd. Eff. Nov. 12, 1971.

Compiler's note: The repealed section pertained to payments for county patients.

Popular name: Act 280

400.66g Expenses of medical or surgical treatment and hospital care of child; reimbursement of health care provider.

Sec. 66g. The expenses of the medical or surgical treatment and hospital care of any child born in the hospital of any woman sent to a hospital under this act, as long as it is considered necessary and proper in the judgment of the hospital physicians to keep the child in the hospital, shall be included in the expense as provided in this act, unless the child is eligible for hospitalization under this act or some other law of this state. A health care provider shall not be granted reimbursement for hospitalization or continued hospitalization of a person under this act unless in the judgment of the admitting or attendant physician there is a reasonable probability of the person being benefited by such hospitalization. This section does not prevent reimbursement from being denied or reduced as provided in section 66k.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957;—Am. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66h Hospitalization; consent to surgical operation, medical treatment; first aid.

Sec. 66h. Nothing in this act shall be construed as empowering any physician or surgeon, or any officer or representative of the state or county departments of social welfare, in carrying out the provisions of this act, to compel any person, either child or adult, to undergo a surgical operation, or to accept any form of medical treatment contrary to the wishes of said person. If the person for whom surgical or medical treatment is recommended is not of sound mind, or is not in a condition to make decisions for himself, the written consent of such person's nearest relative, or legally appointed guardian, or person standing in loco parentis, shall be secured before such medical or surgical treatment is given. This provision is not intended to prevent temporary first aid from being given in case of an accident or sudden acute illness where the consent of those concerned cannot be immediately obtained.

History: Add. 1957, Act 286, Imd. Eff. June 13, 1957.

Popular name: Act 280

400.66i Reimbursement of hospital and state; reimbursement principles; eligibility information as basis of reimbursement; county reimbursement rate; annual adjustment; nonresidents; rules of financial eligibility.

Sec. 66i. (1) Except as provided in subsection (4), the state department, on behalf of a county, shall reimburse the hospital in accordance with established hospital reimbursement principles under title XIX of the social security act, 42 U.S.C. 1396 to 1396d, 1396f to 1396s. However, if state law provides for a different level of reimbursement, the state, on behalf of the county, shall reimburse the hospital at that level of reimbursement. Reimbursement will be based on eligibility information provided to the state department by the county department.

(2) Except as provided in subsection (4), a county department of social services shall reimburse the state an amount equal to the sum of the following:

(a) The total amount the state department approves for payment under subsection (1) to a hospital owned by that county.

(b) The total amount the state department approves for payment to all other hospitals, on behalf of the county, less either $100.00 per day of hospital care or an amount per day established by state law for the county, whichever is higher.

(3) Subsection (2)(b) does not require a county department to reimburse the state under that subdivision when the amount of payments made to the hospitals described in subsection (2)(b), on behalf of the county, is less than either $100.00 per day of hospital care or an amount established by state law for the county, whichever is higher. In addition, subsection (2) does not require the county department to reimburse the state for the cost of the hospitalization for nonresidents of this state.

(4) If the total payments to hospitals by the state department for hospitalization of persons determined by the county department of a county to be eligible for hospitalization under section 66a were less than $2,000,000.00 during the county's full fiscal year immediately before October 1, 1982, the county department of social services of that county may elect to reimburse hospitals directly in accordance with reimbursement principles established by the county department. A county department which elects to reimburse hospitals

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directly shall notify the state department before the beginning of the county's fiscal year in which the election is to become effective. If the county's fiscal year in which the election is to become effective begins in 1983 or a subsequent year, the notice to the state department shall be made at least 60 days before the beginning of the county's fiscal year.

(5) The rules of financial eligibility established pursuant to section 66a in a county on whose behalf the state makes payments to hospitals under subsection (1) shall not be made less restrictive than the rules in effect in the county during the county department's fiscal year ending in 1979.

History: Add. 1979, Act 216, Eff. Oct. 1, 1980;—Am. 1982, Act 255, Eff. Oct. 1, 1982;—Am. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66j Patient care management system; establishment; certification; procedures; recertification; rates of reimbursement and length of hospital stay; contracts; report; system.

Sec. 66j. (1) As an alternative to sections 55(k), 66a, and 66i, a county other than a county described in subsection (2) may establish a patient care management system as described in this section and sections 66k to 66p.

(2) If a county intending to establish a patient care management system is one in which the total payments to hospitals in the county for the county's resident county hospitalization program was less than $10,000,000.00 during the county's full fiscal year immediately preceding the effective date of this section, the county shall apply to the state department for certification of its proposed patient care management system, and the state department shall approve or disapprove the application based upon minimum standards that are established by the state department for county patient care management systems and are based upon this section and sections 66k to 66n. The department shall submit recommended procedures to the appropriate standing committees of the legislature for approval in order to allow other counties to adopt a patient care management system pursuant to this act. Such procedures shall be submitted by January 1, 1989. If a county's original application for certification of a patient care management system is approved under this section, the county shall apply to the state department in each subsequent year for recertification of its patient care management system according to the standards established under this subsection. The application for recertification shall be submitted not later than April 1 of each year, and shall be considered automatically approved by the state department unless denied by the state department, based upon the standards established under this section, within 30 days after being received by the state department. An approval or disapproval of a patient care management system by the state department may be reversed by the legislature by subsequent appropriations legislation or other legislation. An original application for certification or an application for recertification shall be in a form as prescribed by the department.

(3) Under a patient care management system, a county shall establish sufficient rates of reimbursement and appropriate length of stay for inpatient treatments for hospitals and other health care providers and shall contract with hospitals and other health care providers for medical care of persons determined to be eligible by the county. The county shall enter into sufficient contracts to assure that persons determined to be eligible by the county have access to hospital services, physician services, and other medical services considered appropriate by the county board of social services.

(4) A county that establishes a patient care management system annually shall submit a report to the state department containing information on the number of patients served, the services rendered for those patients, the amount of funds spent for those services and the terms of the contracts entered into pursuant to subsection (3). The report shall be submitted not later than 90 days after the end of the county's fiscal year. A county's expenditures for the operation and administration of a patient care management system are subject to audit by the state.

(5) A county that establishes a patient care management system shall create a system to provide the data specified in subsection (4) and to keep track of records of admissions, diagnoses, treatments, and payment records for individuals eligible under the patient care management system.

History: Add. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66k Office; creation; purpose; duties; powers; appeals procedure.

Sec. 66k. (1) A county that establishes a patient care management system shall establish an office to which inquiries may be directed by health care providers under the system concerning the eligibility of patients and past admissions.

(2) An office created pursuant to subsection (1) shall be notified by health care providers of a patient's

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status and shall give or deny authorization for treatment on a timely basis. The office also shall review or provide for the review of utilization of services by patients and by health care providers under the patient care management system. An office may contract for the performance of its duties, subject to supervision of the contractor by the office.

(3) An office created pursuant to subsection (1) may do any of the following:

(a) Deny reimbursement to a health care provider for services determined by the office to be medically unnecessary for the treatment of a patient.

(b) Establish and publish medical protocols that permit either or both of the following:

(*i*) The denial of reimbursement to a health care provider if the services needed by an individual may be provided at another facility under the patient care management system at a lower cost and the patient is physically able to be transferred to that facility.

(*ii*) Reimbursement of the health care provider for the services rendered at the rate of reimbursement for that service at a facility which provides that service at a lower cost.

(4) An office created pursuant to subsection (1) shall implement an appeals procedure for providers of health care who are denied reimbursement, or who receive a lower rate of reimbursement, pursuant to subsection (3).

(5) An office created pursuant to subsection (1) shall develop and implement an appeals procedure for recipients of medical services under a patient care management system, by which a person can appeal the denial to him or her of any or all medical services provided under a patient care management system.

History: Add. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66/ Guidelines for referrals to substance abuse prevention services or substance abuse treatment and rehabilitation services.

Sec. 66*l*. (1) A county that operates a patient care management system shall develop guidelines for referring to appropriate substance abuse prevention services or substance abuse treatment and rehabilitation services an individual whose need for medical care, in whole or in part, is caused by substance abuse.

(2) As used in this section, "substance abuse", "substance abuse prevention services", and "substance abuse treatment and rehabilitation services" mean those terms as defined in section 6107 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

History: Add. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66m Invoices for reimbursement.

Sec. 66m. In a county operating a patient care management system, health care providers shall submit invoices for reimbursement to the office established by the county under section 66k in a manner prescribed by the office. An invoice that is approved for payment by an office shall be paid not later than 60 days after the invoice is received by the office, unless a different time period is established by contract between a health care provider and the county as part of a patient care management system.

History: Add. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.66n Appropriations.

Sec. 66n. (1) If a patient care management system is established in a county in which the total payments to hospitals in the county for the county's resident county hospitalization program exceeded $10,000,000.00 during the county's full fiscal year immediately before the effective date of this section, the state shall appropriate for fiscal year 1988-89 the aggregate amount to the county which the state had appropriated under this act in fiscal year 1987-88 as separate amounts for programs of resident county hospitalization and medical care for general assistance recipients in the county. Funds appropriated to a county under this section shall only be used for a patient care management system as prescribed in sections 66j to 66n, and shall only be made available to the county if the county appropriates and expends for its residential county hospitalization program in the county's fiscal year 1988-89 not less than $15,500,000.00. The ratio of the state's appropriation of $19,500,000.00 to the county appropriation of $15,500,000.00 for the resident county hospitalization program of a county described in this subsection shall be maintained for subsequent fiscal year appropriations by the county, unless the state appropriation is less than $19,500,000.00 in a subsequent year, in which case the county appropriation may decrease in order to maintain the ratio from the base year of $19,500,000.00 state funds to $15,500,000.00 county funds.

(2) If a patient care management system is established in any county other than a county described in

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subsection (1), the state shall appropriate to the county for the state fiscal year following the fiscal year in which the patient care management system is established the aggregate amount which the state had appropriated under this act in the preceding fiscal year as separate amounts for programs of resident county hospitalization and medical care for general assistance recipients in the county. Funds appropriated to a county under this section shall only be used for a patient care management system as prescribed in sections 66j to 66n. Not more than 3% of the funds appropriated to a county under this subsection, and not more than 3% of the county funds appropriated for those same purposes, shall be used for administration of the patient care management system.

(3) For fiscal years following the year in which an aggregate amount is appropriated as prescribed in either subsection (1) or (2), that part of the aggregate amount appropriated that is attributable to former state payments to that county for medical care for general assistance recipients shall be adjusted by any changes in the county's general assistance caseload during the fiscal year immediately preceding the fiscal year in which the appropriation is to be made.

(4) If the cost of medical care in a county under a patient care management system exceeds the amount appropriated to the county under this section in any fiscal year, the county shall be liable for the difference.

(5) Not less than $5,000,000.00 of the funds appropriated under this section to a county described in subsection (1) shall be set aside annually by the county to meet the inpatient hospitalization expenses of persons who are not general assistance recipients as of the date they are admitted to the hospital. If less than the entire $5,000,000.00 is spent in any year for the care of those persons, the remainder may be used for other expenses of the patient care management system.

(6) Any state or local appropriations for a patient care management system that are not expended in the year for which they were appropriated shall be placed by the county in a special fund to be used exclusively for the purposes of the patient care management system in subsequent years.

(7) The state treasurer shall not release funds appropriated to a county for a patient care management system unless the county to which the appropriation is to be made certifies annually to the state administrative board that the county meets the requirements established by this act for a patient care management system, and the state administrative board concurs annually with that certification.

History: Add. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

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400.67 Relief financed by federal funds; denial or revocation of application, appeal, hearing, investigation; decision.

Sec. 67. If any application for aid financed in whole or in part by federal funds is not acted upon by the county department of social welfare within a reasonable time after the filing of the application, or is denied or revoked, in whole or in part, the applicant may appeal to the state department in the manner and form prescribed by the state department and an opportunity for a fair hearing shall be granted by said department as provided in section 9. The state department may also, upon its own motion, review any decision of a county department of social welfare, and may consider any such application upon which a decision has not been made by the county department of social welfare within a reasonable time. The state department may make such additional investigation as it may deem necessary, and shall make such decision as to the granting of aid financed in whole or in part by federal funds and the amount thereof to be granted the applicant as in its opinion is justified and in conformity with the laws of this state. In such cases the decisions of the state department shall be binding upon the county department of social welfare involved and shall be complied with by such county department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.67;—Am. 1957, Act 95, Eff. Sept. 27, 1957;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.68 Application by county board for state and federal moneys.

Sec. 68. The county board shall apply to the state department of social welfare at such time, on such forms, and in such manner, as the state department shall prescribe for the allocation and distribution under section 18 of this act of state or federal moneys available for the several forms of public aid and relief, and with respect to such application shall be governed by the requirements and rules and regulations of the state department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.68.

Popular name: Act 280

Administrative rules: R 400.1 et seq. and R 400.3501 et seq. of the Michigan Administrative Code.

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400.68a County of settlement; itemized statement of relief expense; items of undetermined value.

Sec. 68a. The county department furnishing general relief, including medical care, hospitalization or infirmary care to any poor person at the expense of another county in this state, shall present to the department of social welfare of the county liable for the aid and infirmary care, from time to time as the case might be, a sworn, itemized statement of the expense which shall be allowed and paid by the department of social welfare of the county liable therefor, within 60 days after being presented. No item of the itemized statement of expense shall be a proper and collectible charge against the county which has been determined to be or has agreed to be liable therefor unless submitted within 180 days from the end of the month during which services covered by the item were rendered. In the case of an item, the exact amount of which the county department furnishing care is unable to determine during the 180 days period or prior thereto, notice of the existence of such an item of undetermined amount shall be given the county liable during the 180 days whereupon the county furnishing care shall have an additional 180 days in which to include the amount of the item in an itemized statement.

History: Add. 1957, Act 292, Eff. Sept. 27, 1957.

Popular name: Act 280

400.69 Estimate of funds for social welfare; accounting as to receipts and expenditures; district department of social welfare.

Sec. 69. The county social welfare board shall prepare and submit to the county board of supervisors, at the annual meeting of said board of supervisors or at such other time as the said board of supervisors shall request, an estimate of the funds necessary to carry out the provisions of this act, including funds needed for the several institutions under the jurisdiction of the county social welfare board. The county social welfare board shall also render an account of all moneys received and expended by them. In the case of a district department of social welfare the district social welfare board shall submit such an estimate to the board of supervisors of each county forming a part of such district.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.69;—Am. 1957, Act 292, Eff. Sept. 27, 1957.

Popular name: Act 280

400.70 Appropriation for expenses by county board of supervisors.

Sec. 70. The county board of supervisors shall, within its discretion, make such appropriations as are necessary to maintain the various welfare services within the county, as provided in this act, and to defray the cost of administration of these services. In the case of a district department of social welfare the county board of supervisors of each county forming a part of said district shall appropriate funds necessary to care for the welfare services of such county, and the administrative expenses of the district department shall be defrayed by all of the counties in said district in the proportion that the population of each county, according to the last federal census, bears to the population of the entire district.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.70;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.71 Distinction between township, city, and county poor; abolition.

Sec. 71. Except in respect to a city maintaining a separate department of social welfare under section 48 of this act, the distinction between township, city and county poor is abolished.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.71;—Am. 1957, Act 292, Eff. Sept. 27, 1957;—Am. 1961, Act 184, Eff. Sept. 8, 1961;—Am. 1964, Act 201, Eff. Jan. 1, 1965.

Popular name: Act 280

400.72 Repealed. 1968, Act 117, Imd. Eff. June 11, 1968.

Compiler's note: The repealed section pertained to social welfare moneys in county with city maintaining own department; distribution of expense; levy of taxes.

Popular name: Act 280

400.73 Repealed. 1975, Act 237, Eff. Jan. 1, 1976.

Compiler's note: The repealed section pertained to county treasurer as custodian of moneys.

Popular name: Act 280

400.73a County treasurer as custodian of moneys; creation of social welfare fund; deposits;

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requirements; financial practices.

Sec. 73a. (1) The county treasurer is designated as the custodian of all moneys provided for the use of the county department of social services. The treasurer shall create and maintain a social welfare fund. The following moneys, exclusive of funds which must be deposited in the child care fund, shall be deposited in the social welfare fund:

(a) All moneys raised by the county for the use of the county department of social services.

(b) All funds made available to the county department of social services by the state and federal governments.

(c) All refunds and collections arising out of reimbursements to the county department of social services.

(d) All funds made available to the county department from any other source whatsoever.

(2) Money in the social welfare fund shall remain separate and apart from all other funds of the county and shall not be transferred to or commingled with other funds of the county. The fund shall be used exclusively for carrying out the purposes authorized by this act.

(3) The state department shall prescribe, with respect to the social welfare fund, such subaccounts and expenditure classifications as the state department deems suitable, to comply with requirements to secure federal funds, to facilitate uniform reporting, and for other purposes. The state department may promulgate rules, plans, procedures, and controls with respect to accounting, disbursements, and any other kind of element of financial transactions in connection with the social welfare fund. The county board of commissioners may establish further financial practices not inconsistent with the above. The state department shall prescribe the manner and extent to which the county department shall keep on file vouchers or other authorizations to show the items and reasons for which money is disbursed.

History: Add. 1975, Act 237, Eff. Dec. 1, 1975.

Popular name: Act 280

400.74 Child care and social welfare funds; disbursement; bond; purchases made locally.

Sec. 74. All moneys in the child care fund provided for the use of the county department and all moneys in the social welfare fund shall be disbursed on the order or warrant of the county department, over the signature of a person or persons designated by the board. The board shall require a suitable and adequate bond from all persons designated to sign such orders conditioned for the proper handling of all such disbursements.

All purchases by the board shall, insofar as possible, be placed with business concerns located within the county for which such board is appointed and shall be spread equitably among business concerns.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.74;—Am. 1955, Act 113, Eff. Oct. 14, 1955.

Popular name: Act 280

400.75 County board of auditors; authority.

Sec. 75. In any county now or hereafter having a county board of auditors, such board may discharge such of the custodial, auditing, disbursement, and accounting functions set forth in sections 72, 73 and 74 hereof, and such of the budget making functions set forth in section 69 hereof, as is permitted by existing law, whether general, local or special.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.75.

Popular name: Act 280

400.76 Liability of relatives for support; action for reimbursement of county granting aid; duties of prosecuting attorney; reciprocal enforcement.

Sec. 76. (1) This act shall not be construed to relieve the liability for support by relatives under the provisions of chapter 1 of Act No. 146 of the Public Acts of 1925, as amended, being sections 401.1 to 401.21 of the Compiled Laws of 1948, but shall be construed as superseding the definition of settlement contained in section 1 of chapter 1. The terms of chapter 1 with respect to liability for support by relatives may be invoked in connection with any form of public aid or relief administered under this act.

(2) The social welfare board of the county of legal settlement of a recipient of any form of aid granted under this act, or a social welfare board granting aid, may maintain an action in the circuit court for the county the board represents, or the circuit court for the county in which the defendant resides or is found: (a) Against the county, township or city neglecting or refusing to allow and pay a bill owing under this act and presented more than 90 days prior to the commencement of the action; or (b) Against a recipient of emergency hospitalization or his relatives who are neglecting or refusing to acknowledge responsibility for reimbursement of the county for the costs of the emergency hospitalization; or (c) Against a recipient of hospitalization or his relatives legally liable for his support to enforce its agreement with the recipient or relatives for reimbursement of the county for hospitalization expenses.

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(3) The prosecuting attorney shall represent the county social welfare board in such actions, service or process of courts of like jurisdiction in any county in this state, and such service and return thereof in accordance with law shall give the court in which the action is commenced full jurisdiction to hear and determine the cause. If any legally responsible relative of a poor person receiving or having received any form of public welfare support in this state lives or can be found in some other state which has enacted a uniform reciprocal enforcement of support law, suitable action may be initiated in Michigan by the prosecuting attorney against the legally responsible relative under the provisions of Act No. 8 of the Public Acts of 1952, as amended, being sections 780.151 to 780.172 of the Compiled Laws of 1948.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.76;—Am. 1957, Act 292, Eff. Sept. 27, 1957.

Popular name: Act 280

400.77 Reimbursement of county for welfare relief; relatives or estate; agreements; hospital care, exception; county employees; collection by counties.

Sec. 77. The county department of social welfare is hereby authorized and empowered to collect and receive funds to reimburse the county for expenditures made on behalf of recipients of any form of aid or relief, or hospital care provided at county expense, from such recipients, their relatives legally responsible under the laws of this state for the support of such recipients, or from the estates of recipients, in accordance with the laws of this state, and the rules and regulations of the state department of social welfare, which funds, reimbursed for direct relief, shall be disbursed to carry out the provisions of this act. Agreements for the reimbursement of the county department of social welfare for relief granted to persons or families in their own homes may be required in the cases of applicants whose need for relief is based in whole or in part on inability to obtain funds, moneys, moneys which may be received, income or assets unavailable at the time of application for or grant of relief: Provided, however, That earnings from wages or salaries not due or owing at the time of application for or grant of relief shall not be included in reimbursement agreements. Reimbursements for any form of hospital care provided at county expense shall be collected and paid over by the department of social welfare to the county treasurer for deposit to the fund from which such expenditure was made: Provided, That no county department of social welfare nor any other agency of county government shall collect or receive reimbursements for hospitalization or other treatment for tuberculosis, whether there is an agreement to reimburse the county or not, unless such reimbursement has been ordered by the state commissioner of health or is found acceptable by him as a voluntary reimbursement as provided in section 3a of Act No. 314 of the Public Acts of 1927, as added, being section 329.403a of the Compiled Laws of 1948, and no county department of social welfare shall collect or receive reimbursements for hospitalization or other treatment for any other communicable disease or diseases. Nothing in this section shall be construed to affect the civil service status, if any, of county employees now engaged in collecting reimbursements for the county for any form of aid, relief or hospital care, under the supervision of any other county department. All such employees, and all collection records and files in the county on cases investigated by the department of social welfare prior to the effective date hereof, shall be transferred to and be under the supervision, control and jurisdiction of the board of social welfare in such county.

If a county has acknowledged liability or has reimbursed another county for the cost of any form of aid, relief or hospital care provided at county expense, the county so reimbursed shall credit or remit, as the case may be, to the paying county within 60 days, any additional collections thereon from any other source. It shall be the duty of each county department of social welfare to continue to collect according to its best judgment and ability, if so requested by the county which has acknowledged or paid for any form of aid, relief or hospital care provided at county expense.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.77;—Am. 1949, Act 307, Eff. Sept. 23, 1949;—Am. 1950, Ex. Sess., Act 30, Eff. Mar. 31, 1951;—Am. 1951, Act 126, Eff. Sept. 28, 1951.

Popular name: Act 280

400.77a Old age assistance, aid to dependent children, welfare relief; inconsequential earnings.

Sec. 77a. Under such rules and regulations as the state department of social welfare shall promulgate, inconsequential earnings shall not affect the determination of any amount of assistance to be paid by the state for old age assistance, aid to dependent children or matched by the state in connection with the granting of welfare relief.

History: Add. 1952, Act 235, Eff. Sept. 18, 1952.

Popular name: Act 280

400.77b Repealed. 1973, Act 189, Imd. Eff. Jan. 8, 1974.

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Compiler's note: The repealed section pertained to liability of relative for support.

Popular name: Act 280

400.78 Grants and gifts; acceptance by county board; use of funds; duty of prosecuting attorney.

Sec. 78. The county board may receive on behalf of the county any grant, devise, bequest, donation, gift or assignment of money, bonds or choses in action, or of any property, real or personal, and accept the same, so that the right and title to the same shall pass to the board. All such bonds, notes or choses in action, or the proceeds thereof when collected, and all other property or things of value so received by the board shall be used for the purposes set forth in the grant, devise, bequest, donation, gift, or assignment: Provided, That such purposes shall be within the powers conferred on said board. Whenever it shall be necessary to protect or assert the right or title of the board to any property so received or derived as aforesaid, or to collect or reduce into possession any bond, note, bill or chose in action, the prosecuting attorney is directed to take the necessary and proper proceedings and to bring suits in the name of the board on behalf of the county in any court of competent jurisdiction, state or federal, and to prosecute all such suits.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.78.

Popular name: Act 280

400.79 Prosecuting attorney; duty to give counsel to board or director.

Sec. 79. It shall be the duty of the prosecuting attorney of each county to give his counsel and advice to the board or director whenever the board or director may deem it necessary for the proper discharge of the duties imposed upon them in this act.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.79.

Popular name: Act 280

400.80 County social welfare board; reports to state department.

Sec. 80. It shall be the duty of the county social welfare board to report to the state department monthly, and in such form as the state department shall furnish and prescribe, the activities of the county department. The board shall also make such other and additional reports as shall be required by the state department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.80;—Am. 1957, Act 95, Eff. Sept. 27, 1957.

Popular name: Act 280

400.81 County board; seal; publication of rules and regulations; records and papers as evidence; body corporate, powers.

Sec. 81. The board may devise a seal, and the rules and regulations of the board may be published over the seal of the board. Copies of all records and papers in the office of the county department, certified by a duly authorized agent of the board shall be evidence in all cases equally, and with the like effect, as the originals. The board shall be a body corporate, and is hereby authorized to lease any lands under its jurisdiction and to do any other act or thing necessary in carrying out the provisions of this act.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.81.

Popular name: Act 280

400.82 County board; case examinations, witnesses, attendance and testimony; circuit court enforcement.

Sec. 82. Any member of the board, the director, or supervisor may issue a subpoena requiring any person to appear before the board, director, or supervisor as the case may be, and be examined with reference to any matter within the scope of the inquiry or investigation being conducted and to produce any books, records or papers. Any member of the board, the director, supervisor or any duly authorized agent of the board or director, may administer an oath to a witness in any matter. In case of disobedience of a subpoena, the board, director or supervisor may invoke the aid of the circuit court of the county in which said board is created in requiring the attendance and testimony of witnesses and the production of books, papers and documents. Such circuit court may, in case of contumacy or refusal to obey a subpoena, issue an order requiring such person to appear, and to produce books, records and papers if so ordered and give evidence touching the matter in question. Any failure to obey such order of the court may be punished by such court as a contempt thereof.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.82.

Popular name: Act 280

400.83 Obtaining information from financial institution, department of treasury, employment

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security commission, employer, or former employer; demand or subpoena; definition; computer data matching system; confidentiality.

Sec. 83. (1) The director of the state department of social services or the director of any county department of social services may demand and receive from any financial institution, the Michigan department of treasury, the Michigan employment security commission, employer, or former employer doing business in this state, information with respect to the transactions with any such institution, dates of employment, number of hours worked and rate of pay of an applicant for or recipient of any form of aid or relief under this act. The officers and employees of the institution or employer shall furnish the information on the written demand of the director. A demand directed to a financial institution or an employer shall be in the form of a subpoena issued by the director under section 8 when the identification of applicants and recipients to the financial institution or employer is by means of computer tape or other data process media. The institution or employer shall furnish the information within 15 days after the demand or subpoena is received by the institution or employer.

(2) As used in this section, "financial institution" means a state bank, a national banking association, a state or federal savings and loan association, a federal savings bank, or a state or federal credit union.

(3) The director of the state department shall cooperate with the Michigan employment security commission in the development of a computer data matching system by which records of the department of social services concerning applicants for, and recipients of, assistance under this act shall be compared with claimant and wage information requested on at least a quarterly basis from, and furnished by, the Michigan employment security commission pursuant to sections 11 and 13 of the Michigan employment security act, Act No. 1 of the Public Acts of the Extra Session of 1936, being sections 421.11 and 421.13 of the Michigan Compiled Laws. The computer data matching system shall be used only to determine or verify eligibility of an individual for aid or assistance administered under this act or the amount or type of assistance for which the individual is eligible; to investigate or prosecute instances of alleged fraud; or to establish and collect child support obligations or locate individuals owing child support obligations.

(4) The information obtained under subsection (3) shall be considered confidential and shall not be disclosed by officers or employees of the department of social services to any person or agency except as provided in section 11(b)(2) of Act No. 1 of the Public Acts of the Extra Session of 1936.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.83;—Am. 1976, Act 345, Eff. Mar. 31, 1977;—Am. 1985, Act 140, Imd. Eff. Oct. 28, 1985;—Am. 1985, Act 161, Eff. Dec. 26, 1985.

Popular name: Act 280

400.84 State department; jurisdiction over district and county departments, rules and regulations.

Sec. 84. In respect to matters in which a district department of social welfare differs from a county department of social welfare, the state department shall have the power to promulgate rules and regulations relating to organization, operation and procedure affecting such district or city department, which rules and regulations shall be binding upon all persons and authorities concerned.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.84;—Am. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.85 County superintendents of poor; transfer of powers and duties to county department of social welfare.

Sec. 85. The powers and duties now vested by law in the county superintendents of the poor, except as otherwise provided in subdivision (c) of section 55 of this act, are hereby transferred to and vested in the several county departments of social welfare herein created. Whenever reference is made to the above offices in any law of the state, or whenever reference is made to the supervisor of any township or ward, or to the director of poor of any city, with respect to the powers and duties transferred to the county department of social welfare, reference shall be deemed to be intended to be made to the said county board of social welfare.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.85;—Am. 1957, Act 292, Eff. Sept. 27, 1957.

Popular name: Act 280

400.86 County departments; powers and duties transferred.

Sec. 86. All of the powers and duties prescribed in any law of this state incidental of the transfer of the powers and duties herein provided for shall be transferred to and be vested in the several county departments of social welfare.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.86.

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Popular name: Act 280

400.87 Veterans' relief act not repealed.

Sec. 87. The provisions of this act shall not be construed to repeal or supersede the provisions of Act No. 214 of the Public Acts of 1899, as amended, being sections 35.21 to 35.27 of the Compiled Laws of 1948.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.87;—Am. 1957, Act 95, Eff. Sept. 27, 1957.

Popular name: Act 280

400.88 Repealed. 1957, Act 95, Eff. July 1, 1957.

Compiler's note: The repealed section required that state welfare commission members be appointed, stated effective date of several provisions, and authorized temporary continuance of existing agencies.

Popular name: Act 280

400.90 Political activity or use of position by officers and employes prohibited; penalty.

Sec. 90. No member of the state commission or of any county social welfare board and no executive official or employe of the state or any county welfare department shall participate in any form of political activity other than may be appropriate to the exercise of the individual's rights, duties and privileges or use his official position for any political purpose. Any employe of any department violating this provision shall be subject to discharge or such other disciplinary action as may be provided by the rules and regulations of the state department.

History: 1939, Act 280, Imd. Eff. June 16, 1939;—CL 1948, 400.90.

Popular name: Act 280

400.100 Retirement system service credits; continuation by employees of city or county department when transferred to state department.

Sec. 100. Persons who were employees of a city or county department of social welfare immediately prior to the effective date of this amendatory act, who (1) were members of a city or county retirement system and (2) become members of the state employees' retirement system, shall be entitled to benefits provided by Act No. 88 of the Public Acts of 1961, as amended, entitled "An act to provide for the preservation and continuity of retirement system service credits for public employees who transfer their employment between units of government", notwithstanding that the city or county might not have adopted the said Act No. 88. Whenever the service requirements for benefits to be paid under Act No. 240 of the Public Acts of 1943, as amended, to the said persons who become members of the state employees' retirement system are lower than the service requirements in the said Act No. 88, the provisions of the said Act No. 240 shall apply with respect to the said persons.

History: Add. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.101 Distribution of general relief funds; effective date; state civil service system, membership.

Sec. 101. The distribution of state funds provided in section 18 shall be effective October 1, 1965 and the director and all employees and assistants in counties and cities in which section 23a is not applicable shall become members of the state civil service system on or before July 1, 1967.

History: Add. 1965, Act 401, Imd. Eff. Oct. 27, 1965.

Popular name: Act 280

400.102 Nonduty disability retirement allowance or death benefits; eligibility, conditions.

Sec. 102. Whenever the combined state and city or the combined state and county service of an employee covered by section 100 of this act shall equal or exceed the minimum years of service required by the several units of government under their respective system to be eligible for nonduty disability retirement allowance or benefit, or, for the dependents of such an employee to be eligible for benefits in the event of the nonduty death of such an employee, the state and the city or the county, shall grant such disability or death allowance or benefit upon the following conditions:

(a) That the employee has not withdrawn his accumulated contributions from the retirement system of the city or the county.

(b) That the years of service with the granting unit of government only be used for computing the amount of the retirement allowance or benefit.

(c) That the average final compensation earned from the state, county or city, shall be used for determining

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the amount of the allowance or grant unless otherwise provided in the charter of any other city affected by this act.

If any retirement system does not provide for a nonduty disability retirement allowance or benefit or for nonduty death benefit, then neither the employee nor his dependents shall receive such allowance or benefit from such retirement system nor shall an employee or his dependents receive any retirement allowance or benefit from more than 1 retirement system covering the same service credit period. The provisions of this section shall not apply to any city or county that does not have a retirement system.

History: Add. 1966, Act 249, Imd. Eff. July 11, 1966.

Popular name: Act 280

400.103 Agreements as to eligibility for supplementary benefits and medical assistance.

Sec. 103. (1) A person receiving benefits under title 16 of the social security act or a person who, except for the amount of his income is otherwise eligible to receive benefits, may receive supplementary benefits from the state department in accordance with rules of the state department and to the extent appropriations are available.

(2) The director may enter into an agreement with the secretary of the federal department of health, education and welfare pursuant to title 16 of the social security act, in which the secretary will, on behalf of the state, determine eligibility and make state supplementary payments to eligible persons.

(3) The director may enter into an agreement with the secretary, pursuant to title 16 of the social security act, in which the secretary will determine eligibility for medical assistance in the case of aged, blind, or disabled persons under the state's plan approved under title 19.

History: Add. 1973, Act 189, Imd. Eff. Jan. 8, 1974.

Popular name: Act 280

400.105 Program for medical assistance for medically indigent; establishment; administration; responsibility for determination of eligibility; delegation of authority; definitions.

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

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

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

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

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967;—Am. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.105a Written information setting forth eligibility requirements for participation in program of medical assistance; updating; copies.

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

(2) The department of community health shall provide copies of the written information described in

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subsection (1) to all of the following persons, agencies, and health facilities:

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

(b) Each nursing home in the state.

(c) Each hospital in the state.

(d) Each adult foster care facility in the state.

(e) Each area agency on aging.

(f) The office of services to the aging.

(g) Local health departments.

(h) Community mental health boards.

(i) Medicaid and medicare certified home health agencies.

(j) County medical care facilities.

(k) Appropriate department of community health personnel.

(*l*) Any other person, agency, or health facility determined to be appropriate by the department of community health.

History: Add. 1988, Act 438, Eff. Mar. 30, 1989;—Am. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.105b Medical assistance recipients who practice positive health behaviors; creation of incentives; creation of pay-for-performance incentives for contracted medicaid health maintenance organizations; establishment of preferred product and service formulary program for durable medical equipment; financial support for electronic health records; federal waiver request; conflict with federal statute or regulation prohibited.

Sec. 105b. (1) The department of community health shall create incentives for individual medical assistance recipients who practice specified positive health behaviors. The incentives described in this subsection may include, but are not limited to, expanded benefits and incentives relating to premiums, co-pays, or benefits. The positive health behaviors described in this subsection may include, but are not limited to, participation in health risk assessments and health screenings, compliance with medical treatment, attendance at scheduled medical appointments, participation in smoking cessation treatment, exercise, prenatal visits, immunizations, and attendance at recommended educational health programs.

(2) The department of community health shall create pay-for-performance incentives for contracted medicaid health maintenance organizations. The medicaid health maintenance organization contracts shall include incentives for meeting health outcome targets for chronic disease states, increasing the number of medical assistance recipients who practice positive health behaviors, and meeting patient compliance targets established by the department of community health. Priority shall be given to strategies that prevent and manage the 10 most prevalent and costly ailments affecting medical assistance recipients.

(3) The department of community health shall establish a preferred product and service formulary program for durable medical equipment. The department of community health shall work with the centers for medicare and medicaid services to determine if a joint partnership with medicare is possible in establishing the program described in this subsection as a means of achieving savings and efficiencies for both the medicaid and medicare programs. The preferred product and service formulary program for durable medical equipment shall require participation from the department of community health and shall permit the contracted medicaid health maintenance organizations and provider organizations to participate.

(4) The department of community health shall seek financial support for electronic health records, including, but not limited to, personal health records, e-prescribing, web-based medical records, and other health information technology initiatives using medicaid funds.

(5) The department of community health shall include in any federal waiver request that is submitted with the intent to secure federal matching funds to cover the medically uninsured nonmedicaid population in the state language to allow the department of community health to establish, at a minimum, the programs required under subsections (1) and (2).

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(6) The department of community health shall not implement incentives under this section that conflict with federal statute or regulation.

History: Add. 2007, Act 100, Imd. Eff. Oct. 1, 2007.

Popular name: Act 280

400.105c Determination of medicaid eligibility and enrollment; submission of recommendation by director.

Sec. 105c. The director of the department of community health shall submit a recommendation to the senate majority leader, the speaker of the house, and the state budget office on how to most effectively determine medicaid eligibility and enrollment for all applicants by January 1, 2015. The department of community health may delegate this function to another state agency, perform the function directly, or contract with a private or nonprofit entity, consistent with state law.

History: Add. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.105d Medical assistance program; waiver; acceptance of Medicare rates by hospital as payments in full; submission of approved waiver provisions to legislature; enrollment plan; pharmaceutical benefit; cost-sharing compliance bonus pool; Medicaid hospital cost report; baseline uncompensated care report; insurance rates and insurance rate change filings; evaluation by department of insurance and financial services; reports; financial incentives; performance bonus incentive pool; limitation on administrative costs; uniform procedures and compliance metrics; distribution of funds from performance bonus incentive pool; substance abuse disorders; options after 48 cumulative months of medical assistance coverage; availability of data to vendor; failure to receive waivers; inapplicability of section; offset of state tax refunds; liability; emergency department overutilization and improper usage; symposium and report; review of reports by independent third party vendor; "legislature" defined; definitions.

Sec. 105d. (1) The department shall seek a waiver from the United States Department of Health and Human Services to do, without jeopardizing federal match dollars or otherwise incurring federal financial penalties, and upon approval of the waiver shall do, all of the following:

(a) Enroll individuals eligible under section 1396a(a)(10)(A)(i)(VIII) of title XIX who meet the citizenship provisions of 42 CFR 435.406 and who are otherwise eligible for the medical assistance program under this act into a contracted health plan that provides for an account into which money from any source, including, but not limited to, the enrollee, the enrollee's employer, and private or public entities on the enrollee's behalf, can be deposited to pay for incurred health expenses, including, but not limited to, co-pays. The account shall be administered by the department and can be delegated to a contracted health plan or a third party administrator, as considered necessary.

(b) Ensure that contracted health plans track all enrollee co-pays incurred for the first 6 months that an individual is enrolled in the program described in subdivision (a) and calculate the average monthly co-pay experience for the enrollee. The average co-pay amount shall be adjusted at least annually to reflect changes in the enrollee's co-pay experience. The department shall ensure that each enrollee receives quarterly statements for his or her account that include expenditures from the account, account balance, and the cost-sharing amount due for the following 3 months. The enrollee shall be required to remit each month the average co-pay amount calculated by the contracted health plan into the enrollee's account. The department shall pursue a range of consequences for enrollees who consistently fail to meet their cost-sharing requirements, including, but not limited to, using the MIChild program as a template and closer oversight by health plans in access to providers.

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

(d) Ensure that all enrollees described in subdivision (a) have access to a primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state and to

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preventive services. The department shall require that all new enrollees be assigned and have scheduled an initial appointment with their primary care practitioner within 60 days of initial enrollment. The department shall monitor and track contracted health plans for compliance in this area and consider that compliance in any health plan incentive programs. The department shall ensure that the contracted health plans have procedures to ensure that the privacy of the enrollees' personal information is protected in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.

(e) Require enrollees described in subdivision (a) with annual incomes between 100% and 133% of the federal poverty guidelines to contribute not more than 5% of income annually for cost-sharing requirements. Cost-sharing includes co-pays and required contributions made into the accounts authorized under subdivision (a). Contributions required in this subdivision do not apply for the first 6 months an individual described in subdivision (a) is enrolled. Required contributions to an account used to pay for incurred health expenses shall be 2% of income annually. Except as otherwise provided in subsection (20), notwithstanding this minimum, required contributions may be reduced by the contracting health plan. The reductions may occur only if healthy behaviors are being addressed as attested to by the contracted health plan based on uniform standards developed by the department in consultation with the contracted health plans. The uniform standards shall include healthy behaviors such as completing a department approved annual health risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and immunization status. Except as otherwise provided in subsection (20), co-pays can be reduced if healthy behaviors are met, but not until annual accumulated co-pays reach 2% of income except co-pays for specific services may be waived by the contracted health plan if the desired outcome is to promote greater access to services that prevent the progression of and complications related to chronic diseases. If the enrollee described in subdivision (a) becomes ineligible for medical assistance under the program described in this section, the remaining balance in the account described in subdivision (a) shall be returned to that enrollee in the form of a voucher for the sole purpose of purchasing and paying for private insurance.

(f) Implement a co-pay structure that encourages use of high-value services, while discouraging low-value services such as nonurgent emergency department use.

(g) During the enrollment process, inform enrollees described in subdivision (a) about advance directives and require the enrollees to complete a department-approved advance directive on a form that includes an option to decline. The advance directives received from enrollees as provided in this subdivision shall be transmitted to the peace of mind registry organization to be placed on the peace of mind registry.

(h) Develop incentives for enrollees and providers who assist the department in detecting fraud and abuse in the medical assistance program. The department shall provide an annual report that includes the type of fraud detected, the amount saved, and the outcome of the investigation to the legislature.

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

(2) For services rendered to an uninsured individual, a hospital that participates in the medical assistance program under this act shall accept 115% of Medicare rates as payments in full from an uninsured individual with an annual income level up to 250% of the federal poverty guidelines. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(3) Not more than 7 calendar days after receiving each of the official waiver-related written correspondence from the United States Department of Health and Human Services to implement the provisions of this section, the department shall submit a written copy of the approved waiver provisions to the legislature for review.

(4) The department shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees as described in subsection (1)(a). The department shall include contracted health plans as the mandatory delivery system in its waiver request. The department also shall pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the 4 integrated care demonstration regions. The department shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans. The department shall make recommendations for a performance bonus incentive plan for long-term care managed care providers of up to 3% of their Medicaid capitation payments, consistent with other managed care performance bonus incentive plans. These payments shall comply with federal requirements and shall be based on

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measures that identify the appropriate use of long-term care services and that focus on consumer satisfaction, consumer choice, and other appropriate quality measures applicable to community-based and nursing home services. Where appropriate, these quality measures shall be consistent with quality measures used for similar services implemented by the integrated care for duals demonstration project. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(5) The department shall implement a pharmaceutical benefit that utilizes co-pays at appropriate levels allowable by the Centers for Medicare and Medicaid Services to encourage the use of high-value, low-cost prescriptions, such as generic prescriptions when such an alternative exists for a branded product and 90-day prescription supplies, as recommended by the enrollee's prescribing provider and as is consistent with section 109h and sections 9701 to 9709 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

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

(7) The department shall develop a methodology that decreases the amount an enrollee's required contribution may be reduced as described in subsection (1)(e) based on, but not limited to, factors such as an enrollee's failure to pay cost-sharing requirements and the enrollee's inappropriate utilization of emergency departments.

(8) The program described in this section is created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift attendant to uncompensated care. Uncompensated care does not include courtesy allowances or discounts given to patients. The Medicaid hospital cost report shall be part of the uncompensated care definition and calculation. In addition to the Medicaid hospital cost report, the department shall collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the actual cost of uncompensated care. This shall be reported for all hospitals in the state. By December 31, 2014, the department shall make an initial baseline uncompensated care report containing at least the data described in this subsection to the legislature and each December 31 after that shall make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report shall use fiscal year 2012-2013 data. Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in this state, the department shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general fund savings. The department shall recognize any savings from this reduction by September 30, 2016. All the reports required under this subsection shall be made available to the legislature and shall be easily accessible on the department's website.

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

(10) The department shall explore and develop a range of innovations and initiatives to improve the effectiveness and performance of the medical assistance program and to lower overall health care costs in this

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state. The department shall report the results of the efforts described in this subsection to the legislature and to the house and senate fiscal agencies by September 30, 2015. The report required under this subsection shall also be made available and easily accessible on the department's website. The department shall pursue a broad range of innovations and initiatives as time and resources allow that shall include, at a minimum, all of the following:

(a) The value and cost-effectiveness of optional Medicaid benefits as described in federal statute.

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

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

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

(e) Review and evaluation of the current design principles that serve as the foundation for the state's medical assistance program to ensure the program is cost-effective and that appropriate incentive measures are utilized. The review shall include, at a minimum, the auto-assignment algorithm and performance bonus incentive pool. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

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

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

(12) The department in collaboration with the contracted health plans and providers shall create financial incentives for all of the following:

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

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

(c) Enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a health risk assessment as identified by their primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

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

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

(15) The department shall maintain administrative costs at a level of not more than 1% of the department's appropriation of the state medical assistance program. These administrative costs shall be capped at the total administrative costs for the fiscal year ending September 30, 2016, except for inflation and project-related costs required to achieve medical assistance net general fund savings. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(16) The department shall establish uniform procedures and compliance metrics for utilization by the contracted health plans to ensure that cost-sharing requirements are being met. This shall include ramifications for the contracted health plans' failure to comply with performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

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(17) The department shall withhold, at a minimum, 0.75% of payments to contracted health plans, except for specialty prepaid health plans, for the purpose of expanding the existing performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the contracted health plan's completion of the required performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(18) The department shall withhold, at a minimum, 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the specialty prepaid health plan's completion of the required performance of compliance metrics that shall include, at a minimum, partnering with other contracted health plans to reduce nonemergent emergency department utilization, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the United States Department of Veterans Affairs. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(19) The department shall measure contracted health plan or specialty prepaid health plan performance metrics, as applicable, on application of standards of care as that relates to appropriate treatment of substance use disorders and efforts to reduce substance use disorders. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(20) By October 1, 2018, in addition to the waiver requested in subsection (1), the department shall seek an additional waiver from the United States Department of Health and Human Services that requires individuals who are between 100% and 133% of the federal poverty guidelines and who have had medical assistance coverage for 48 cumulative months beginning on the date of their enrollment into the program described in subsection (1) by the date of the waiver implementation to choose 1 of the following options:

(a) Complete a healthy behavior as provided in subsection (1)(e) with intentional effort given to making subsequent year healthy behaviors incrementally more challenging in order to continue to focus on eliminating health-related obstacles inhibiting enrollees from achieving their highest levels of personal productivity and pay a premium of 5% of income. A required contribution for a premium is not eligible for reduction or refund.

(b) Suspend eligibility for the program described in subsection (1)(a) until the individual complies with subdivision (a).

(21) The department shall notify enrollees 60 days before the enrollee would lose coverage under the current program that this coverage is no longer available to them and that, in order to continue coverage, the enrollee must comply with the option described in subsection (20)(a).

(22) The medical coverage for individuals described in subsection (1)(a) shall remain in effect for not longer than a 16-month period after submission of a new or amended waiver request under subsection (20) if a new or amended waiver request is not approved within 12 months after submission. The department must notify individuals described in subsection (1)(a) that their coverage will be terminated by February 1, 2020 if a new or amended waiver request is not approved within 12 months after submission.

(23) If a new or amended waiver requested under subsection (20) is denied by the United States Department of Health and Human Services, medical coverage for individuals described in subsection (1)(a) shall remain in effect for a 16-month period after the date of submission of the new or amended waiver request unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended waiver request. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the chairs of the senate and house of representatives appropriations subcommittees on the department budget, at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver request under this subsection is not approved within the 12-month period described in this subsection, the department must give 4 months' notice that medical coverage for individuals described in subsection (1)(a) shall be terminated.

(24) If a new or amended waiver requested under subsection (20) is canceled by the United States Department of Health and Human Services or is invalidated, medical coverage for individuals described in subsection (1)(a) shall remain in effect for 16 months after the date of submission of a new or amended waiver unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended

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waiver. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the senate and house of representatives appropriations subcommittees on the department budget at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver under this subsection is not approved within the 12-month period described in this subsection, the department must give 4 months' notice that medical coverage for individuals described in subsection (1)(a) shall be terminated.

(25) If a new or amended waiver request under subsection (23) or (24) is approved by the United States Department of Health and Human Services but does not comply with the other requirements of this section, medical coverage for individuals described in subsection (1)(a) shall be terminated 4 months after the new or amended waiver has been determined to be in noncompliance. The department must notify individuals described in subsection (1)(a) at least 4 months before the termination date that enrollment shall be terminated and the reason for termination.

(26) Individuals described in 42 CFR 440.315 are not subject to the provisions of the waiver described in subsection (20).

(27) The department shall make available at least 3 years of state medical assistance program data, without charge, to any vendor considered qualified by the department who indicates interest in submitting proposals to contracted health plans in order to implement cost savings and population health improvement opportunities through the use of innovative information and data management technologies. Any program or proposal to the contracted health plans must be consistent with the state's goals of improving health, increasing the quality, reliability, availability, and continuity of care, and reducing the cost of care of the eligible population of enrollees described in subsection (1)(a). The use of the data described in this subsection for the purpose of assessing the potential opportunity and subsequent development and submission of formal proposals to contracted health plans is not a cost or contractual obligation to the department or the state.

(28) This section does not apply if either of the following occurs:

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

(b) If federal government matching funds for the program described in this section are reduced below 100% and annual state savings and other nonfederal net savings associated with the implementation of that program are not sufficient to cover the reduced federal match. The department shall determine and the state budget office shall approve how annual state savings and other nonfederal net savings shall be calculated by June 1, 2014. By September 1, 2014, the calculations and methodology used to determine the state and other nonfederal net 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.

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

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

(31) By November 30, 2013, the department shall convene a symposium to examine the issues of emergency department overutilization and improper usage. The department shall submit a report to the legislature that identifies the causes of overutilization and improper emergency service usage that includes specific best practice recommendations for decreasing overutilization of emergency departments and improper emergency service usage, as well as how those best practices are being implemented. Both broad recommendations and specific recommendations related to the Medicaid program, enrollee behavior, and health plan access issues shall be included.

(32) The department shall contract with an independent third party vendor to review the reports required in subsections (8) and (9) and other data as necessary, in order to develop a methodology for measuring, tracking, and reporting medical cost and uncompensated care cost reduction or rate of increase reduction and

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their effect on health insurance rates along with recommendations for ongoing annual review. The final report and recommendations shall be submitted to the legislature by September 30, 2015.

(33) For the purposes of submitting reports and other information or data required under this section only, "legislature" means the senate majority leader, the speaker of the house of representatives, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on the department budget, and the chairs of the senate and house of representatives standing committees on health policy.

(34) As used in this section:

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

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

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

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

History: Add. 2013, Act 107, Eff. Mar. 14, 2014;—Am. 2018, Act 208, Eff. Sept. 20, 2018.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.105e Appropriations.

Sec. 105e. (1) There is appropriated for the department of community health and the department of corrections to supplement appropriations for the fiscal year ending September 30, 2014 an adjusted gross appropriation of $1,524,903,500.00 appropriated from $1,704,523,500.00 in federal revenues, $13,145,000.00 in other state restricted revenues and a negative appropriation of $192,765,000.00 in state general fund/general purpose revenue.

(2) There is appropriated for the department of community health for medicaid reform a gross appropriation of $1,549,115,700.00 appropriated from $1,704,523,500.00 in federal revenues, $13,145,000.00 in other state restricted revenues, and a negative appropriation of $168,552,800.00 in state general fund/general purpose revenue with $1,395,876,600.00 for medical services reform, $288,646,900.00 for mental health reform, and $40,000,000.00 for administration, and negative appropriations to reflect savings with $1,072,200.00 for plan first family planning waiver, $14,723,900.00 for medicaid adult benefits waiver, $6,680,600.00 for medicaid adult benefits waiver (mental health), and $152,931,100.00 for community mental health non-medicaid services.

(3) There is appropriated for the department of corrections a negative adjusted gross appropriation of $24,212,200.00 in state general fund/general purpose revenue with a negative appropriation of $3,566,600.00 for prison re-entry and community support, including a negative $377,200.00 for prisoner re-entry local service providers and a negative $3,189,400.00 for prisoner re-entry department of corrections programs; a negative appropriation of $8,066,100.00 for substance abuse testing and treatment services in field operations administration; and a negative appropriation of $12,579,500.00 for prisoner health care services in health care.

(4) The appropriations in subsections (1), (2), and (3) for the department of community health for medicaid reform are not available for expenditure until approval of the federal waiver in section 105d(1), except that the funds associated with administrative expenses are available for immediate expenditure. The administrative expenditures shall not exceed $20,000,000.00 in general fund. The department of community health shall

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enter into memoranda of understanding with departments that incur administrative expenditures related to the program identified in section 105d(1).

History: Add. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.105f Michigan health care cost and quality advisory committee.

Sec. 105f. (1) The director of the department of community health and the director of the department of insurance and financial services shall establish a Michigan health care cost and quality advisory committee consisting of 8 or more members.

(2) The director of the department of community health, or his or her designee, and 1 department of community health staff member and the director of the department of insurance and financial services, or his or her designee, and 1 department of insurance and financial services staff member are members of the committee established in subsection (1). The chairs and minority vice chairs of the senate and house health policy committees or their designees are members of the committee. The committee members shall elect a chairperson and appoint additional members to the advisory committee established in subsection (1) necessary to perform the duties prescribed in this section.

(3) The advisory committee established in subsection (1) shall issue a report by December 31, 2014 with recommendations on the creation of a database on health care costs and health care quality in this state. This report shall be transmitted to the legislature and made available on the department of community health's and the department of insurance and financial services' websites. The advisory committee shall include in the report at least all of the following:

(a) A review of existing efforts across the United States to make health care cost and quality more transparent.

(b) A review of proposed legislation in this state to make health care cost and quality more transparent.

(c) A review of any existing standards governing the operation of similar databases.

(d) A consideration of both price and quality of health care services rendered in this state.

(e) Transparency and privacy issues.

(f) The possible impact of uncompensated care on commercial insurance rates.

(g) Other methods to accurately estimate the uncompensated care impact on commercial insurance rates.

(4) This section applies whether or not either or both of the waivers requested under section 105d are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

History: Add. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.106 Medically indigent individual; definitions; notice of legal action; requirements; violation; civil fine; recovery of expenses by the department or contracted health plan; priority against proceeds; release of claims; subrogation of interests.

Sec. 106. (1) As used in this act, "medically indigent individual" means any of the following:

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

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

(*i*) The individual has applied in the manner the department prescribes.

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(*ii*) The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or resources of the patient. The department is subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of money expended by the department for the care and treatment of the patient. The patient or other person acting on the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an injury or disability for which the individual is entitled to medical care or reimbursement for the cost of medical care under chapter 31 of the insurance code of 1956, 1956 PA 218, MCL 500.3101 to 500.3179, or under another policy of insurance providing medical or hospital benefits, or both, for the individual unless the individual's entitlement to that medical care or reimbursement is at issue. If a payment is made, the department, to enforce its subrogation right, may do either of the following: (a) intervene or join in an action or proceeding brought by the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual; (b) institute and prosecute a legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled individual, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. The department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled individual, the individual's guardian, personal representative, estate, dependents, or survivors. As provided in section 6023 of the revised judicature act of 1961, 1961 PA 236, MCL 600.6023, the department, in enforcing its subrogation right, shall not satisfy a judgment against the third person's property that is exempt from levy and sale. The injured, diseased, or disabled individual may proceed in his or her own name, collecting the costs without the necessity of joining the department or the state as a named party. The injured, diseased, or disabled individual shall notify the department of the action or proceeding entered into upon commencement of the action or proceeding. An action taken by the state or the department in connection with the right of recovery afforded by this section does not deny the injured, diseased, or disabled individual any part of the recovery beyond the costs expended on the individual's behalf by the department. The costs of legal action initiated by the state must be paid by the state. A payment must not be made under this act for medical assistance for an injury, disease, or disability for which the individual is entitled to medical care or the cost of medical care under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, entitlement has not been finally determined, and an arrangement satisfactory to the department has been made for reimbursement if the claim under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, is finally sustained.

(*iii*) The individual has an annual income that is below, or subject to limitations imposed by the director and because of medical expenses falls below, the protected basic maintenance level. The protected basic maintenance level for 1-person and 2-person families must be not less than 100% of the payment standards generally used to determine eligibility in the family independence program. For families of 3 or more persons, the protected basic maintenance level must be not less than 100% of the payment standard generally used to determine eligibility in the family independence program. These levels must recognize regional variations and must not exceed 133-1/3% of the payment standard generally used to determine eligibility in the family independence program.

(*iv*) The individual, if a family independence program related individual and living alone, has liquid or marketable assets of not more than $2,000.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than $3,000.00 in value. The department shall establish comparable liquid or marketable asset amounts for larger family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead; clothing; household effects; $1,000.00 of cash surrender value of life insurance, except that if the health of the insured makes continuance of the insurance desirable, the entire cash surrender value of life insurance is excluded from consideration, up to the maximum provided or allowed by federal regulations and in accordance with department rules; the fair market value of tangible personal property used in earning income; an amount paid as judgment or settlement for damages suffered as a result of exposure to Agent Orange as defined in section 5701 of the public health code, 1978

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PA 368, MCL 333.5701; and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program, the appropriate resource levels and property exemptions specified in title XVI must be used.

(*v*) Except as provided in section 106b, the individual is not an inmate of a public institution except as a patient in a medical institution.

(*vi*) The individual meets the eligibility standards for supplemental security income under title XVI or for state supplementation under the act, subject to limitations imposed by the director of the department according to title XIX; or meets the eligibility standards for family independence program benefits; or meets the eligibility standards for optional eligibility groups under title XIX, subject to limitations imposed by the director of the department according to title XIX.

(c) An individual who is eligible under section 1396a(a)(10)(A)(i)(VIII) of title XIX, also known as the healthy Michigan plan. This subdivision does not apply if either of the following occurs:

(*i*) If the department is unable to obtain a federal waiver as provided in section 105d(1) or (20).

(*ii*) If federal government matching funds for the program described in section 105d are reduced below 100% and annual state savings and other nonfederal net savings associated with the implementation of that program are not sufficient to cover the reduced federal match. The department shall determine and the state budget office shall approve how annual state savings and other nonfederal net savings must be calculated by June 1, 2014. By September 1, 2014, the calculations and methodology used to determine the state and other nonfederal net savings must be submitted to the legislature.

(2) As used in this act:

(a) "Contracted health plan" means a managed care organization with whom the department contracts to provide or arrange for the delivery of comprehensive health care services as authorized under this act.

(b) "Federal poverty guidelines" means the poverty guidelines published annually in the Federal Register by the United States Department of Health and Human Services under its authority to revise the poverty line under section 673(2) of subtitle B of title VI of the omnibus budget reconciliation act of 1981, 42 USC 9902.

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

(d) "Title XVI" means title XVI of the social security act, 42 USC 1381 to 1383f.

(3) An individual receiving medical assistance under this act, his or her representative, or his or her legal counsel, or all 3, shall notify the department and, if the individual is enrolled in a contracted health plan, the contracted health plan if either of the following occurs:

(a) The individual, his or her representative, or his or her legal counsel, or all 3, file a complaint in which the department or the contracted health plan may have a right to recover expenses paid under this act.

(b) The individual, his or her representative, or his or her legal counsel, or all 3, seek to settle an action, without filing a complaint, in which the department or the contracted health plan may have a right to recover expenses paid under this act.

(4) The notice required under subsection (3)(a), along with a copy of the complaint and all documents filed with the complaint, must be provided to the department and, if applicable, the contracted health plan within 30 days after the complaint is filed with the court. The individual, his or her representative, or his or her legal counsel shall certify that notice and a copy of the complaint have been provided to the department and, if applicable, the contracted health plan on the summons and complaint form. This certification must be made in cases with the following case type codes: NF (no-fault automobile insurance), NH (medical malpractice), NI (personal injury, auto negligence), NO (other personal injury), and NP (product liability), and in any other case in which the department or the contracted health plan may have a right to recover expenses paid under this act. The state court administrator shall revise the summons and complaint form to allow certification under this subsection.

(5) The notice required under subsection (3)(b) must be provided in writing to the department and, if applicable, the contracted health plan before the action is settled and must include the proposed settlement terms, including the settlement amount, attorney costs, attorney fees, and Medicaid health plan or Medicare subrogation interest amounts, if applicable.

(6) If notice is not given as required by subsections (3) through (5), the department or the contracted health plan may file a legal action against the individual, his or her representative, or his or her legal counsel, or all 3, to recover expenses paid under this act. The attorney general or the contracted health plan shall recover any cost or attorney fees associated with a recovery under this subsection.

(7) An attorney who knowingly fails to timely notify the department or the contracted health plan as required by this section is subject, at the discretion of the department, to a $1,000.00 civil fine for each violation. The civil fine is payable to the department and must be deposited in the general fund. The money

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deposited in the general fund under this subsection may be used to offset the cost to this state for operating the Medicaid program.

(8) The department has first priority against the proceeds of the net recovery from the settlement or judgment in an action settled in which notice has been provided under subsection (3). A contracted health plan has priority immediately after the department in an action settled in which notice has been provided under subsection (3). The department and a contracted health plan shall recover the full cost of expenses paid under this act unless the department or the contracted health plan agrees to accept an amount less than the full amount. If the individual would recover less against the proceeds of the net recovery than the expenses paid under this act, the department or the contracted health plan, and the individual shall share equally in the proceeds of the net recovery. The department or a contracted health plan is not required to pay an attorney fee on the net recovery. As used in this subsection, "net recovery" means the total settlement or judgment less the costs and fees incurred by or on behalf of the individual who obtains the settlement or judgment.

(9) The individual, his or her representative, or his or her legal counsel shall not release the claims of the department or the contracted health plan against third parties or insurers without the consent of the department or the contracted health plan.

(10) All of the following apply with respect to the subrogation interest of the department or the contracted health plan, or both:

(a) Within 30 days of receiving the notice required under this act, the department and, if applicable, a contracted health plan shall provide to the individual, his or her representative, or his or her legal counsel, a written itemization of expenses paid under this act for which the third party may be liable.

(b) If the department or a contracted health plan fails to provide the notice required by subdivision (a), the obligation of the individual, his or her representative, or his or her legal counsel, or all 3, to protect the subrogation interest of the department or the contracted health plan, or both if both failed to provide notice, is discharged. The department or the contracted health plan retains the right to pursue recovery through its own means.

(c) A reported subrogation amount is valid unless supplemented by the department or a contracted health plan.

(d) An individual, his or her representative, or his or her legal counsel, or all 3, satisfy the obligation to protect the subrogation interest of the department or a contracted health plan if a settlement agreement provides for reimbursement of the total amount of expenses in the last received written itemization from the department or the contracted health plan, reduced by any applicable fees and costs for which a reduction is allowed under statute or administrative rule.

CAUTION This document is from an archive and may contain outdated information.

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967;—Am. 1970, Act 160, Imd. Eff. Aug. 2, 1970;—Am. 1973, Act 189, Imd. Eff. Jan. 8, 1974;—Am. 1976, Act 284, Imd. Eff. Oct. 20, 1976;—Am. 1978, Act 623, Imd. Eff. Jan. 6, 1979;—Am. 1982, Act 405, Eff. Mar. 30, 1983;—Am. 1990, Act 145, Imd. Eff. June 27, 1990;—Am. 2003, Act 33, Imd. Eff. July 2, 2003;—Am. 2004, Act 409, Imd. Eff. Nov. 29, 2004;—Am. 2006, Act 144, Imd. Eff. May 22, 2006;—Am. 2013, Act 107, Eff. Mar. 14, 2014;—Am. 2014, Act 452, Imd. Eff. Jan. 2, 2015;—Am. 2018, Act 511, Imd. Eff. Dec. 28, 2018.

Compiler's note: For transfer of powers and duties of the home help program and the physical disabilities program from the family independence agency to the director of the department of community health, see E.R.O. No. 1997-5, compiled at MCL 400.224 of the Michigan Compiled Laws.

Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.106a "Michigan freedom to work for individuals with disabilities law" as short title of section; medical assistance to individuals with earned income; establishment of program; limitation; permitted acts; premium; basis; sliding fee scale; revenue; limitation; waiver; definitions.

Sec. 106a. (1) This section shall be known and may be cited as the "Michigan freedom to work for individuals with disabilities law".

(2) The department of community health shall establish a program to provide medical assistance to individuals who have earned income and who meet all of the following initial eligibility criteria:

(a) The individual has been found to be disabled under the federal supplemental security income program or the social security disability income program, or would be found to be disabled except for earnings in

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excess of the substantial gainful activity level as established by the United States social security administration.

(b) The individual is at least 16 years of age and younger than 65 years of age.

(c) The individual has a countable income level of not more than 250% of the current federal poverty guidelines for a family of 1.

(d) The individual's assets meet the medicare part D extra help low income subsidy (LIS) and medicare savings program (MSP) asset limit, as adjusted annually.

(e) The individual is employed on a regular and continuing basis.

(3) The program is limited to the medical assistance services made available to recipients under the medical assistance program administered under section 105.

(4) Without losing eligibility for medical assistance, an individual who qualifies for and is enrolled under this program is permitted to do all of the following:

(a) Accumulate personal savings and assets not to exceed $75,000.00.

(b) Accumulate unlimited retirement and individual retirement accounts with income from employment while enrolled in the freedom to work for individuals with disabilities program. Assets described in this subdivision shall remain excluded from eligibility consideration for other medicaid programs for the individual even if he or she loses eligibility under this section.

(c) Have temporary breaks in employment that do not exceed 24 months if the temporary breaks are the result of an involuntary layoff or are determined to be medically necessary or for relocation necessary due to employment in this state.

(d) Work and have income that exceeds the amount permitted under section 106, but shall not have unearned income that exceeds 250% of the federal poverty guidelines.

(5) The department of community health shall establish a premium that is based on the enrolled individual's earned and unearned income. An enrolled individual shall pay a sliding fee scale monthly premium based on an annual review of total gross income as follows:

(a) No premium for individuals with gross income less than 138% of the federal poverty guidelines for a family of 1.

(b) Beginning the effective date of the 2014 amendatory act that amended this subdivision, a premium of up to 7.5% per month of gross income for individuals who have total gross income between 138% of the federal poverty guidelines for a family of 1 and $75,000.00 annual adjusted gross income.

(c) A premium of 100% of the average freedom to work program participant cost for an enrolled individual with adjusted gross income over $75,000.00 annually.

(d) The premium for an enrolled individual shall generally be assessed on an annual basis based on the annual return required to be filed under the internal revenue code of 1986 or other evidence of earned income and shall be payable on a monthly basis. The premium shall be adjusted during the year when a change in an enrolled individual's rate of annual income changes.

(6) Revenue received from premiums collected under this section shall not exceed $3,000,000.00 per year.

(7) If the terms of this section are inconsistent with federal regulations governing federal financial participation in the medical assistance program, the department of community health may to the extent necessary waive any requirement set forth in subsections (1) to (6).

(8) As used in this section:

(a) "Adjusted gross income" means that term as defined in section 62 of the internal revenue code of 1986.

(b) "Countable income", "earned income", and "unearned income" mean those terms as used by the department in determining eligibility for the medical assistance program administered under this act.

(c) "Federal poverty guidelines" means the poverty guidelines published annually in the federal register by the United States department of health and human services under its authority to revise the poverty line under section 673(2) of subtitle B of title VI of the omnibus budget reconciliation act of 1981, 42 USC 9902.

History: Add. 2003, Act 32, Imd. Eff. July 2, 2003;—Am. 2012, Act 356, Eff. Mar. 28, 2013;—Am. 2014, Act 518, Imd. Eff. Jan. 14, 2015.

Popular name: Act 280

400.106b Suspension of medical assistance; conditions; inmate residing in public institution; redetermination of eligibility; reinstatement; limitation; applicability; defintions.

Sec. 106b. (1) The state medicaid plan shall require the department of community health to suspend rather than terminate an individual's medical assistance when either of the following applies:

(a) The individual becomes an inmate residing in a public institution but otherwise remains eligible for medical assistance.

(b) An inmate was not eligible for medical assistance when he or she entered the public institution but is

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subsequently determined to be eligible for medical assistance while in the public institution.

(2) The department of community health shall redetermine the medical assistance eligibility of the individual.

(3) Upon notification that an individual described in subsection (1) is no longer an inmate residing in a public institution, the department of community health shall reinstate the individual's medical assistance if the individual is otherwise eligible for medical assistance.

(4) This section does not extend medical assistance eligibility to an otherwise ineligible individual or extend medical assistance to an individual if matching federal funds are not available to pay for the medical assistance.

(5) This section applies to the department of community health, a state agency to which the department of community health has delegated these functions as provided under section 105c, or a private or nonprofit entity with which the department of community health has contracted to perform these functions as provided under section 105c.

(6) As used in this section:

(a) "Public institution" means 1 of the following:

(*i*) An inpatient program operated by the department of community health for treatment of individuals with serious emotional disturbance or serious mental illness.

(*ii*) A local correctional facility as that term is defined in section 2 of the local corrections officers training act, 2003 PA 125, MCL 791.532.

(*iii*) A correctional facility as that term is defined in section 15 of the corrections code of 1953, 1953 PA 232, MCL 791.215.

(*iv*) A youth correctional facility operated by the department of corrections or a private vendor under section 20g of the corrections code of 1953, 1953 PA 232, MCL 791.220g.

(b) "Serious emotional disturbance" and "serious mental illness" mean those terms as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

History: Add. 2014, Act 452, Imd. Eff. Jan. 2, 2015.

Popular name: Act 280

400.107 Medically indigent; financial eligibility; income.

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

(2) The department of community health shall apply a modified adjusted gross income methodology in determining if an individual's annual income level is below 133% of the federal poverty guidelines.

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967;—Am. 2006, Act 144, Imd. Eff. May 22, 2006;—Am. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.107a Workforce engagement requirements; definitions.

Sec. 107a. (1) The purpose of adding workforce engagement requirements to the medical assistance program as provided in section 107b is to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from government interference.

(2) As used in this section and section 107b:

(a) "Able-bodied adult" means an individual at least 19 to 62 years of age who is not pregnant and who does not have a disability that makes him or her eligible for medical assistance under section 105d.

(b) "Caretaker" means a parent or an individual who is taking care of a child in the absence of a parent or an individual caring for a disabled individual as described in section 107b(1)(f)(*v*). A caretaker is not subject to the workforce engagement requirements established under section 107b if he or she is not a medical

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assistance recipient under section 105d.

(c) "Child" means an individual who is not emancipated under 1968 PA 293, MCL 722.1 to 722.6 who lives with a parent or caretaker, and who is either of the following:

(*i*) Under the age of 18.

(*ii*) Age 18 and a full-time high school student.

(d) "Good cause temporary exemption" means:

(*i*) The recipient is an individual with a disability as described in subtitle A of title II of the Americans with disabilities act of 1990, 42 USC 12131 to 12134, section 504 of title V of the rehabilitation act of 1973, 29 USC 794, or section 1557 of the patient protection and affordable care act, Public Law 111-148, who is unable to meet the workforce engagement requirements for reasons related to that disability.

(*ii*) The recipient has an immediate family member in the home with a disability under federal disability rights laws and is unable to meet the workforce engagement requirements for reasons related to the disability of that family member.

(*iii*) The recipient or an immediate family member, who is living in the home with the recipient, experiences hospitalization or serious illness.

(e) "Incapacitated individual" means that term as defined in section 1105 of the estates and protected individuals code, 1998 PA 386, MCL 700.1105.

(f) "Medically frail" means that term as described in 42 CFR 440.315(f).

(g) "Qualifying activity" means any of the following:

(*i*) Employment or self-employment, or having income consistent with being employed or self-employed. As used in this subparagraph, "having income consistent with being employed or self-employed" means an individual makes at least minimum wage for an average of 80 hours per month.

(*ii*) Education directly related to employment, including, but not limited to, high school equivalency test preparation program and postsecondary education.

(*iii*) Job training directly related to employment.

(*iv*) Vocational training directly related to employment.

(*v*) Unpaid workforce engagement directly related to employment, including, but not limited to, an internship.

(*vi*) Tribal employment programs.

(*vii*) Participation in substance use disorder treatment.

(*viii*) Community service.

(*ix*) Job search directly related to job training.

(h) "Recipient" means an individual receiving medical assistance under this act.

(i) "Substance use disorder" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

(j) "Unemployment benefits" means benefits received under the Michigan employment security act, 1936 (Ex Sess) PA 1, MCL 421.1 to 421.75.

History: Add. 2018, Act 208, Eff. Sept. 20, 2018.

Popular name: Act 280

400.107b Workforce engagement requirements waiver; implementation; survey; compliance review.

Sec. 107b. (1) No later than October 1, 2018, the department must apply for or apply to amend a waiver under section 1115 of the social security act, 42 USC 1315, and submit subsequent waivers to prohibit and prevent a lapse in the workforce engagement requirements as a condition of receiving medical assistance under section 105d. The waiver must be a request to allow for all of the following:

(a) A requirement of 80 hours average per month of qualifying activities or a combination of any qualifying activities, to count toward the workforce engagement requirement under this section.

(b) A requirement that able-bodied recipients verify that they are meeting the workforce engagement requirements by the tenth of each month for the previous month's qualifying activities through MiBridges or any other subsequent system. A recipient is allowed 3 months of noncompliance within a 12-month period. The recipient may use a noncompliance month either by self-reporting that he or she is not in compliance that month or by the default method of not reporting compliance for that month. The department shall notify the recipient after each time a noncompliance month is used. After a recipient uses 3 noncompliance months in a 12-month period, the recipient loses coverage for at least 1 month until he or she becomes compliant under this section.

(c) Allow substance use disorder treatment that is court-ordered, prescribed by a licensed medical professional, or is a Medicaid-funded substance use disorder treatment, to count toward the workforce

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engagement requirements if the treatment impedes the ability to meet the workforce engagement requirements.

(d) A requirement that community service must be completed with a nonprofit organization that is exempt from taxation under section 501(c)(3) or 501(c)(4) of the internal revenue code of 1986, 26 USC 501. Community service can only be used as a qualifying activity for up to 3 months in a 12-month period.

(e) A requirement that a recipient who is also a recipient of the supplemental nutrition assistance program or the temporary assistance for needy families program who is in compliance with or exempt from the work requirements of the supplemental nutrition assistance program or the temporary assistance for needy families program is considered to be in compliance with or exempt from the workforce engagement requirements in this section.

(f) An exemption for a recipient who meets 1 or more of the following conditions:

(*i*) A recipient who is the caretaker of a family member who is under the age of 6 years. This exemption allows only 1 parent at a time to be a caretaker, no matter how many children are being cared for.

(*ii*) A recipient who is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.

(*iii*) A recipient who is a full-time student who is not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid. This subparagraph includes a student in a postsecondary institution or certificate program.

(*iv*) A recipient who is pregnant.

(*v*) A recipient who is the caretaker of a dependent with a disability which dependent needs full-time care based on a licensed medical professional's order. This exemption is allowed 1 time per household.

(*vi*) A recipient who is the caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker.

(*vii*) A recipient who has proven that he or she has met the good cause temporary exemption.

(*viii*) A recipient who has been designated as medically frail.

(*ix*) A recipient who has a medical condition that results in a work limitation according to a licensed medical professional's order.

(*x*) A recipient who has been incarcerated within the last 6 months.

(*xi*) A recipient who is receiving unemployment benefits from this state. This exemption applies during the period the recipient received unemployment benefits and ends when the recipient is no longer receiving unemployment benefits.

(*xii*) A recipient who is under 21 years of age who had previously been in a foster care placement in this state.

(2) After the waiver requested under this section is approved, the department must include, but is not limited to, all of the following, as approved in the waiver, in its implementation of the workforce engagement requirements under this section:

(a) A requirement of 80 hours average per month of qualifying activities or a combination of any qualifying activities counts toward the workforce engagement requirement under this section.

(b) A requirement that able-bodied recipients must verify that they are meeting the workforce engagement requirements by the tenth of each month for the previous month's qualifying activities through MiBridges or any other subsequent system. A recipient is allowed 3 months of noncompliance within a 12-month period. The recipient may use a noncompliance month either by self-reporting that he or she is not in compliance that month or by the default method of not reporting compliance for that month. The department shall notify the recipient after each time a noncompliance month is used. After a recipient uses 3 noncompliance months in a 12-month period, the recipient loses coverage for at least 1 month until he or she becomes compliant under this section.

(c) Allowing substance use disorder treatment that is court-ordered, is prescribed by a licensed medical professional, or is a Medicaid-funded substance use disorder treatment, to count toward the workforce engagement requirements if the treatment impedes the ability to meet the workforce engagement requirements.

(d) A requirement that community service must be completed with a nonprofit organization that is exempt from taxation under section 501(c)(3) or 501(c)(4) of the internal revenue code of 1986, 26 USC 501. Community service can only be used as a qualifying activity for up to 3 months in a 12-month period.

(e) A requirement that a recipient who is also a recipient of the supplemental nutrition assistance program or the temporary assistance for needy families program who is in compliance with or exempt from the work requirements of the supplemental nutrition assistance program or the temporary assistance for needy families program is considered to be in compliance with or exempt from the workforce engagement requirements in this section.

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(f) An exemption for a recipient who meets 1 or more of the following conditions:

(*i*) A recipient who is the caretaker of a family member who is under the age of 6 years. This exemption allows only 1 parent at a time to be a caretaker, no matter how many children are being cared for.

(*ii*) A recipient who is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.

(*iii*) A recipient who is a full-time student who is not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid. This subparagraph includes a student in a postsecondary institution or a certificate program.

(*iv*) A recipient who is pregnant.

(*v*) A recipient who is the caretaker of a dependent with a disability which dependent needs full-time care based on a licensed medical professional's order. This exemption is allowed 1 time per household.

(*vi*) A recipient who is the caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker.

(*vii*) A recipient who has proven that he or she has met the good cause temporary exemption.

(*viii*) A recipient who has been designated as medically frail.

(*ix*) A recipient who has a medical condition that results in a work limitation according to a licensed medical professional's order.

(*x*) A recipient who has been incarcerated within the last 6 months.

(*xi*) A recipient who is receiving unemployment benefits from this state. This exemption applies during the period the recipient received unemployment benefits and ends when the recipient is no longer receiving unemployment benefits.

(*xii*) A recipient who is under 21 years of age who had previously been in a foster care placement in this state.

(3) The department may first direct recipients to existing resources for job training or other employment services, child care assistance, transportation, or other supports. The department may develop strategies for assisting recipients to meet workforce engagement requirements under this section.

(4) Beginning October 1, 2018 and each year the department submits a waiver to prohibit and prevent a lapse in the workforce engagement requirements after that, the Medicaid director must submit to the governor, the senate majority leader, and the speaker of the house of representatives a letter confirming the submission of the waiver request required under subsection (1).

(5) Beginning January 1, 2020, the department must execute a survey to obtain the information needed to complete an evaluation of the medical assistance program under section 105d to determine how many recipients have left the Healthy Michigan program as a result of obtaining employment and medical benefits.

(6) The department must execute a survey to obtain the information needed to submit a report to the legislature beginning January 1, 2021, and every January 1 after that, that shows, for medical assistance under section 105d known as Healthy Michigan, the number of exemptions from workforce engagement requirements granted to individuals in that year and the reason the exemptions were granted.

(7) The department shall enforce the provisions of this section by conducting the compliance review process on medical assistance recipients under section 105d who are required to meet the workforce engagement requirements of this section. If a recipient is found, through the compliance review process, to have misrepresented his or her compliance with the workforce engagement requirements in this section, he or she shall not be allowed to participate in the Healthy Michigan program under section 105d for a 1-year period.

(8) The department shall implement the requirements of this section no later than January 1, 2020, and shall notify recipients to whom the workforce engagement requirements described in this section are likely to apply of the workforce engagement requirements 90 days in advance.

(9) The cost of initial implementation of the workforce engagement requirements required under this section shall not be considered when determining the cost-benefit analysis required under section 105d(28)(b). The cost of initial implementation does not include the cost of ongoing administration of the workforce engagement requirements. The ongoing costs of administering the workforce engagement requirements required under this section may have up to a $5,000,000.00 general fund/general purpose revenue limit that shall not be counted when determining the cost-benefit analysis required under section 105d(28)(b). Any ongoing costs above $5,000,000.00 of general fund/general purpose revenue to administer the workforce engagement requirements under this section shall be considered in the cost-benefit analysis required under section 105d(28)(b).

(10) Beginning January 1, 2020, medical assistance recipients who are not exempt from the workforce engagement requirements under this section must be in compliance with this section. Beginning January 1, 2020, a medical assistance applicant who is not exempt from the work engagement requirements under this

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section must be in compliance with this section not more than 30 days after an eligibility determination is made.

(11) The department shall not withdraw, terminate, or amend any waiver submitted under this section without the express approval of the legislature in the form of a bill enacted by law.

History: Add. 2018, Act 208, Eff. Sept. 20, 2018.

Popular name: Act 280

400.108 Medical or dental services to which medically indigent entitled; certification; services to eligible children.

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

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967;—Am. 1972, Act 367, Imd. Eff. Jan. 9, 1973;—Am. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

400.109 Medical services provided under act; notice and approval of proposed change in method or level of reimbursement; definitions.

Sec. 109. (1) The following medical services may be provided under this act:

(a) Hospital services that an eligible individual may receive consist of medical, surgical, or obstetrical care, together with necessary drugs, X-rays, physical therapy, prosthesis, transportation, and nursing care incident to the medical, surgical, or obstetrical care. The period of inpatient hospital service shall be the minimum period necessary in this type of facility for the proper care and treatment of the individual. Necessary hospitalization to provide dental care shall be provided if certified by the attending dentist with the approval of the department. An individual who is receiving medical treatment as an inpatient because of a diagnosis of mental disease may receive service under this section, notwithstanding the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106. The department shall pay for hospital services according to the state plan for medical assistance adopted under section 10 and approved by the United States Department of Health and Human Services.

(b) An eligible individual may receive physician services authorized by the department. The service may be furnished in the physician's office, the eligible individual's home, a medical institution, or elsewhere in case of emergency. A physician shall be paid a reasonable charge for the service rendered. Reasonable charges shall be determined by the department and shall not be more than those paid in this state for services rendered under title XVIII.

(c) An eligible individual may receive nursing home services in a state licensed nursing home, a medical care facility, or other facility or identifiable unit of that facility, certified by the appropriate authority as meeting established standards for a nursing home under the laws and rules of this state and the United States Department of Health and Human Services, to the extent found necessary by the attending physician, dentist, or certified Christian Science practitioner. An eligible individual may receive nursing services in an extended care services program established under section 22210 of the public health code, 1978 PA 368, MCL

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333.22210, to the extent found necessary by the attending physician when the combined length of stay in the acute care bed and short-term nursing care bed exceeds the average length of stay for Medicaid hospital diagnostic related group reimbursement. The department shall not make a final payment under title XIX for benefits available under title XVIII without documentation that title XVIII claims have been filed and denied. The department shall pay for nursing home services according to the state plan for medical assistance adopted according to section 10 and approved by the United States Department of Health and Human Services. A county shall reimburse a county maintenance of effort rate determined on an annual basis for each patient day of Medicaid nursing home services provided to eligible individuals in long-term care facilities owned by the county and licensed to provide nursing home services. For purposes of determining rates and costs described in this subdivision, all of the following apply:

(*i*) For county-owned facilities with per patient day updated variable costs exceeding the variable cost limit for the county facility, county maintenance of effort rate means 45% of the difference between per patient day updated variable cost and the concomitant nursing home-class variable cost limit, the quantity offset by the difference between per patient day updated variable cost and the concomitant variable cost limit for the county facility. The county rate shall not be less than zero.

(*ii*) For county-owned facilities with per patient day updated variable costs not exceeding the variable cost limit for the county facility, county maintenance of effort rate means 45% of the difference between per patient day updated variable cost and the concomitant nursing home class variable cost limit.

(*iii*) For county-owned facilities with per patient day updated variable costs not exceeding the concomitant nursing home class variable cost limit, the county maintenance of effort rate shall equal zero.

(*iv*) For the purposes of this section: "per patient day updated variable costs and the variable cost limit for the county facility" shall be determined according to the state plan for medical assistance; for freestanding county facilities the "nursing home class variable cost limit" shall be determined according to the state plan for medical assistance and for hospital attached county facilities the "nursing class variable cost limit" shall be determined according to the state plan for medical assistance plus $5.00 per patient day; and "freestanding" and "hospital attached" shall be determined according to the federal regulations.

(*v*) If the county maintenance of effort rate computed under this section exceeds the county maintenance of effort rate in effect as of September 30, 1984, the rate in effect as of September 30, 1984 shall remain in effect until a time that the rate computed under this section is less than the September 30, 1984 rate. This limitation remains in effect until December 31, 2022. For each subsequent county fiscal year, the maintenance of effort rate may not increase by more than $1.00 per patient day each year.

(*vi*) For county-owned facilities, reimbursement for plant costs will continue to be based on interest expense and depreciation allowance unless otherwise provided by law.

(d) An eligible individual may receive pharmaceutical services from a licensed pharmacist of the person's choice as prescribed by a licensed physician or dentist and approved by the department. In an emergency, but not routinely, the individual may receive pharmaceutical services rendered personally by a licensed physician or dentist on the same basis as approved for pharmacists.

(e) An eligible individual may receive other medical and health services as authorized by the department.

(f) Psychiatric care may also be provided according to the guidelines established by the department to the extent of appropriations made available by the legislature for the fiscal year.

(g) An eligible individual may receive screening, laboratory services, diagnostic services, early intervention services, and treatment for chronic kidney disease under guidelines established by the department. A clinical laboratory performing a creatinine test on an eligible individual under this subdivision shall include in the lab report the glomerular filtration rate (eGFR) of the individual and shall report it as a percentage of kidney function remaining.

(h) An eligible individual may receive medically necessary acute medical detoxification for opioid use disorder, medically necessary inpatient care at an approved facility, or care in an appropriately licensed substance use disorder residential treatment facility.

(2) The director shall provide notice to the public, according to applicable federal regulations, and shall obtain the approval of the committees on appropriations of the house of representatives and senate of the legislature of this state, of a proposed change in the statewide method or level of reimbursement for a service, if the proposed change is expected to increase or decrease payments for that service by 1% or more during the 12 months after the effective date of the change.

(3) As used in this act:

(a) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-5.

(c) "Title XX" means title XX of the social security act, 42 USC 1397 to 1397n-13.

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History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967;—Am. 1970, Act 160, Imd. Eff. Aug. 2, 1970;—Am. 1972, Act 367, Imd. Eff. Jan. 9, 1973;—Am. 1977, Act 79, Imd. Eff. Aug. 2, 1977;—Am. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1980, Act 391, Imd. Eff. Jan. 7, 1981;—Am. 1984, Act 408, Imd. Eff. Dec. 28, 1984;—Am. 1990, Act 193, Imd. Eff. July 24, 1990;—Am. 1990, Act 261, Imd. Eff. Oct. 15, 1990;—Am. 1994, Act 352, Imd. Eff. Dec. 22, 1994;—Am. 1995, Act 277, Imd. Eff. Jan. 8, 1996;—Am. 1996, Act 473, Imd. Eff. Dec. 26, 1996;—Am. 1997, Act 173, Imd. Eff. Dec. 30, 1997;—Am. 2000, Act 168, Imd. Eff. June 20, 2000;—Am. 2002, Act 673, Imd. Eff. Dec. 26, 2002;—Am. 2006, Act 327, Imd. Eff. Aug. 10, 2006;—Am. 2006, Act 576, Imd. Eff. Jan. 3, 2007;—Am. 2011, Act 53, Imd. Eff. June 8, 2011;—Am. 2012, Act 48, Imd. Eff. Mar. 13, 2012;—Am. 2016, Act 551, Eff. Apr. 10, 2017;—Am. 2017, Act 253, Eff. Mar. 27, 2018;—Am. 2018, Act 315, Imd. Eff. June 29, 2018.

Compiler's note: For transfer of powers and duties of the home help program and the physical disabilities program from the family independence agency to the director of the department of community health, see E.R.O. No. 1997-5, compiled at MCL 400.224 of the Michigan Compiled Laws.

Popular name: Act 280

400.109a Abortion as service provided with public funds to welfare recipient; prohibition; exception; policy.

Sec. 109a. Notwithstanding any other provision of this act, an abortion shall not be a service provided with public funds to a recipient of welfare benefits, whether through a program of medical assistance, general assistance, or categorical assistance or through any other type of public aid or assistance program, unless the abortion is necessary to save the life of the mother. It is the policy of this state to prohibit the appropriation of public funds for the purpose of providing an abortion to a person who receives welfare benefits unless the abortion is necessary to save the life of the mother.

History: Add. 1987, Act 59, Eff. Dec. 12, 1988.

Constitutionality: The Michigan Supreme Court considered an argument by plaintiffs in Doe v Department of Social Services, 439 Mich 650 (1992), that the state's refusal to pay for a therapeutic abortion violates the equal protection guarantee of the Michigan Constitution. Plaintiffs argued that S 400.109a provides unequal treatment to two classes of indigent, pregnant women — those who choose childbirth and those who chose abortion. The trial court in the case granted defendant's motion for summary disposition and dismissed the suit. The court of appeals reversed, 187 Mich App 493 (1991), concluding that (1) the equal protection guarantee in the Michigan Constitution provided greater protection than the corresponding guarantee in the federal constitution and (2) that the statute directly interferes with the women's right to an abortion. The Michigan Supreme Court reversed the court of appeals, holding that (1) there is no evidence of an intent in the Michigan Constitution to provide broader protection than its federal counterpart and (2) the state's decision to fund childbirth, but not abortion, does not impinge upon the exercise of a fundamental right. The Michigan Supreme Court, in upholding the validity of the statute under rational basis test, concluded that Michigan's Constitution permits the state to fund childbirth expenses even though it does not fund abortions.

Compiler's note: This added section was proposed by initiative petition pursuant to Const 1963, art 2, § 9. On June 17, 1987, the initiative petition was approved by an affirmative vote of the majority of the Senators elect and filed with the Secretary of State. On June 23, 1987, the initiative petition was approved by an affirmative vote of the majority of the Members elect of the House of Representatives and filed with the Secretary of State. The Legislature did not vote pursuant to Const 1963, art 4, § 27, to give immediate effect to this enactment.

In Frey v Director, Department of Social Services, 162 Mich App 586; 413 NW2d 54 (1987), the Michigan Court of Appeals held that Const 1963, art 4, § 27, applies to initiative laws and that without the required two-thirds vote of each house of the Legislature, as provided by Const 1963, art 4, § 27, Act 59 of 1987 could not take effect until the expiration of 90 days from the end of the session at which it was passed.

In affirming the decision of the Court of Appeals in Frey, the Michigan Supreme Court held that when a law is proposed by initiative and enacted by the Legislature without change or amendment within forty days as required by Const 1963, art 2, § 9, it takes effect ninety days after the end of the session in which it was passed unless two-thirds of the members of each house of the Legislature, as provided by art 4, § 27, vote to give the law immediate effect. Act 59 of 1987, not having received votes in favor of immediate effect by two-thirds of the elected members of each house, may not take effect until ninety days after the end of the session in which it was enacted. Frey v Director, Department of Social Services, 429 Mich 315; 414 NW2d 873 (1987).

On March 1, 1988, petitions to invoke the power of referendum with regard to Act 59 of 1987 were filed with the Secretary of State. On April 13, 1988, the Board of State Canvassers certified the validity of a sufficient number of petition signatures to invoke the referendum. In a letter opinion to C. Patrick Babcock, Director, Department of Social Services, dated March 28, 1988, the Attorney General addressed the following question: "[I]f the filing of petitions, which include, if they are valid, a sufficient number of signatures to properly invoke a referendum, stays the effective date of Act 59 of 1987, which will otherwise become effective on March 30, 1988?" The Attorney General concluded that "when a petition seeking referendum, which on its face meets legal requirements, is filed the signatures appearing on that petition are presumed valid and the statute at issue is stayed or suspended until either the petitions are found to be invalid or a vote of the people occurs."

Act 59 of 1987, as enacted by the Legislature, was submitted to the people by referendum petition and approved by a majority of the votes cast at the general election held November 8, 1988. The Board of State Canvassers officially declared the vote to be 1,959,727 (for) and 1,486,371 (against) on December 2, 1988.

Popular name: Act 280

400.109b Modification of formula for indigent care volume price adjustor.

Sec. 109b. Beginning October 1, 1988, the formula for the indigent care volume price adjustor shall be modified in such a manner as to distribute, in addition to the $30,000,000.00 appropriated for indigent care in fiscal year 1987-88, not less than $24,000,000.00 annually to hospitals that provide a large proportion of their

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services to indigent persons.

History: Add. 1987, Act 266, Imd. Eff. Dec. 28, 1987.

Popular name: Act 280

400.109c Home- or community-based services; eligibility; safeguards; written plan of care; available services; per capita expenditure; waiver; rules; report; changing plan of care; hearing; appeal; expansion of program; implementation of program by department of community health and office of services to the aging.

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

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

(a) Home delivered meals.

(b) Chore services.

(c) Homemaker services.

(d) Respite care.

(e) Personal care.

(f) Adult day care.

(g) Private duty nursing.

(h) Mental health counseling.

(i) Caregiver training.

(j) Emergency response systems.

(k) Home modification.

(*l*) Transportation.

(m) Medical equipment and supply services.

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

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

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

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

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

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

(c) The number of persons and the annual expenditure for personal care services.

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

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

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

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

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

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

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

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

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

(d) Not later than July 14, 1998, home- and community-based services shall be available to eligible applicants on a statewide basis.

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

History: Add. 1988, Act 410, Imd. Eff. Dec. 27, 1988;—Am. 1994, Act 302, Imd. Eff. July 14, 1994;—Am. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: For transfer of powers and duties of the home help program and the physical disabilities program from the family independence agency to the director of the department of community health, see E.R.O. No. 1997-5, compiled at MCL 400.224 of the Michigan Compiled Laws.

Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

For transfer of commission on services to the aging and powers and duties of the office of services to the aging from the department of community health to the aging and adult services agency created within the department of health and human services, and abolishment of the office of services to the aging, see E.R.O. No. 2015-1, compiled at MCL 400.227.

Popular name: Act 280

400.109d Services relating to performing abortions; prohibitions.

Sec. 109d. (1) The legislature finds that the use of medicaid funds for elective abortions has been clearly rejected by the people of Michigan through Act No. 59 of the Public Acts of 1987, initiated by the citizens under the rights of the people reserved in the Michigan constitution, approved by a majority of this legislature, affirmed by the citizens at large through a statewide referendum, and sustained by the Michigan supreme court.

(2) In light of evidence that abortion providers, in conjunction with third party payors, may have devised and implemented plans for reimbursing services in violation of the intent of Act No. 59 of the Public Acts of 1987, the legislature finds the enactment of section 109e a necessary clarification of, and enforcement mechanism for, Act No. 59 of the Public Acts of 1987.

(3) The legislature finds that any practice of separating or unbundling services directly related to the performance of an abortion for the purposes of seeking medicaid reimbursement, with those funds thereby subsidizing in whole or in part the cost of performing an abortion, is an inappropriate use of taxpayer funds in light of Act No. 59 of the Public Acts of 1987.

(4) Recognizing that certain services related to performing an abortion can also be part of legitimate and routine obstetric care, section 109e should not be construed to affect diagnostic testing or other nonabortion procedures. Only physicians who actually perform abortions, and particularly those who perform abortions but do not provide prenatal care or obstetric services, should view themselves as potentially affected by

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section 109e. Unacceptable requests for reimbursement include those services which would not have been performed, but for the preparation and performance of a planned or requested abortion.

History: Add. 1996, Act 124, Eff. Mar. 31, 1997.

Popular name: Act 280

400.109e Definitions; reimbursement for performance of abortion; prohibition; violation; penalty; enforcement; scope of section.

Sec. 109e. (1) As used in this section:

(a) "Abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus. Abortion does not include the use or prescription of a drug or device intended as a contraceptive.

(b) "Health care professional" means an individual licensed or registered under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws.

(c) "Health facility or agency" means a health facility or agency licensed under article 17 of Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws.

(2) A health care professional or a health facility or agency shall not seek or accept reimbursement for the performance of an abortion knowing that public funds will be or have been used in whole or in part for the reimbursement in violation of section 109a of Act No. 280 of the Public Acts of 1939, being section 400.109a of the Michigan Compiled Laws, as added by Act No. 59 of the Public Acts of 1987.

(3) A person who violates this section is liable for a civil fine of up to $10,000.00 per violation. The department of community health shall investigate an alleged violation of this section and the attorney general, in cooperation with the department of community health, may bring an action to enforce this section.

(4) Nothing in this section restricts the right of a health care professional to discuss abortion or abortion services with a patient who is pregnant.

(5) This section does not create a right to an abortion.

(6) Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

History: Add. 1996, Act 124, Eff. Mar. 31, 1997.

Popular name: Act 280

400.109f Medicaid-covered specialty services and supports; management and delivery; specialty prepaid health plans; section inapplicable to pilot project.

Sec. 109f. (1) The department shall support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance use disorder. Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department. The specialty services and supports shall be carved out from the basic Medicaid health care benefits package.

(2) Specialty prepaid health plans are Medicaid managed care organizations as described in section 1903(m)(1)(A) of title XIX, 42 USC 1396b, and are responsible for providing defined inpatient services, outpatient hospital services, physician services, other specified Medicaid state plan services, and additional services approved by the Centers for Medicare and Medicaid Services under section 1915(b)(3) of title XIX, 42 USC 1396n.

(3) This section does not apply to a pilot project authorized under section 298(3) of article X of 2017 PA 107.

History: Add. 2000, Act 410, Imd. Eff. Jan. 8, 2001;—Am. 2005, Act 84, Imd. Eff. July 19, 2005;—Am. 2017, Act 224, Eff. Mar. 20, 2018.

Popular name: Act 280

400.109g Specialty services panel; creation; purpose; membership; qualifications; terms; vacancy; conflict of interest; advisory capacity; meetings.

Sec. 109g. (1) The governor shall create a specialty services panel within the department of community health to review and make determinations regarding applications for participation submitted by community mental health services programs or other managing entities.

(2) The specialty services panel shall consist of the following members, appointed by the governor:

(a) The director of the department of community health or his or her representative.

(b) Two members who represent the department of community health, excluding an individual appointed

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under subdivision (a).

(c) The director of the department of management and budget or his or her representative.

(d) Four members who represent primary consumers or family members.

(e) Five members who represent other stakeholders, including, but not limited to, 1 representative each from the statewide advocacy organizations representing adults with serious mental illness, children with serious emotional disturbance, individuals with substance abuse disorders, and individuals with developmental disabilities. At least 1 member appointed under this subdivision shall be a county commissioner.

(3) No member appointed under subsection (2)(d) or (e) shall provide direct services or represent providers who provide services for reimbursement under this act to an individual who qualifies for specialty services.

(4) Members of the specialty services panel shall serve for terms of 4 years or until a successor is appointed, whichever is later, except that, of the members first appointed, 4 shall serve for 1 year, 5 shall serve for 2 years, and 4 shall serve for 3 years.

(5) If a vacancy occurs on the specialty services panel, the governor shall make an appointment for the unexpired term in the same manner as the original appointment.

(6) A member of the specialty services panel shall make known any matter in which that member has a potential conflict of interest.

(7) The specialty services panel shall remain in existence to serve in an advisory capacity to the director of the department of community health regarding performance and quality relating to medicaid specialty services and supports. The panel shall meet no less than 2 times a year. The panel shall have access to all aggregate quality management information gathered by the department of community health relating to the managing entities.

History: Add. 2000, Act 409, Imd. Eff. Jan. 8, 2001.

Compiler's note: For abolishment of the specialty services panel and transfer of its powers and duties to the department of community health, see E.R.O. No. 2007-13, compiled at MCL 333.26326.

Popular name: Act 280

400.109h Prior authorization for certain prescription drugs not required; drugs under contract between department and health maintenance organization; definitions.

Sec. 109h. (1) If the department of community health develops a prior authorization process for prescription drugs as part of the pharmaceutical services offered under the medical assistance program administered under this act, it shall not require prior authorization for the following single source brand name, generic equivalent of a multiple source brand name, or other prescription drugs:

(a) A central nervous system prescription drug that is classified as an anticonvulsant, antidepressant, antipsychotic, or a noncontrolled substance antianxiety drug in a generally accepted standard medical reference.

(b) A prescription drug that is cross-indicated for a central nervous system drug exempted under subdivision (a) as documented in a generally accepted standard medical reference.

(c) Unless the prescription drug is a controlled substance or the prescription drug is being prescribed to treat a condition that is excluded from coverage under this act, a prescription drug that is recognized in a generally accepted standard medical reference as effective in the treatment of conditions specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association. The department or the department's agent shall not deny a request for prior authorization of a controlled substance under this subdivision unless the department or the department's agent determines that the controlled substance or the dosage of the controlled substance being prescribed is not consistent with its licensed indications or with generally accepted medical practice as documented in a standard medical reference.

(d) A prescription drug that is recognized in a generally accepted standard medical reference for the treatment of and is being prescribed to a patient for the treatment of any of the following:

(*i*) Human immunodeficiency virus infections or the complications of the human immunodeficiency virus or acquired immunodeficiency syndrome.

(*ii*) Cancer.

(*iii*) Organ replacement therapy.

(*iv*) Epilepsy or seizure disorder.

(2) This section does not apply to drugs being provided under a contract between the department and a health maintenance organization.

(3) As used in this section:

(a) "Controlled substance" means that term as defined in section 7104 of the public health code, 1978 PA

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368, MCL 333.7104.

(b) “Cross-indicated” means a drug which is used for a purpose generally held to be reasonable, appropriate, and within community standards of practice even though the use is not included in the federal food and drug administration's approved labeled indications for that drug.

(c) “Department” means the department of community health.

(d) “Prescriber” means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(e) “Prescription” or “prescription drug” means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(f) “Prior authorization” means a process implemented by the department of community health that conditions, delays, or denies the delivery of particular pharmaceutical services to medicaid beneficiaries upon application of predetermined criteria by the department or the department's agent for those pharmaceutical services covered by the department on a fee-for-service basis or pursuant to a contract for those services. The process may require a prescriber to verify with the department or the department's agent that the proposed medical use of a prescription drug being prescribed for a patient meets the predetermined criteria for a prescription drug that is otherwise covered under this act or require a prescriber to obtain authorization from the department or the department's agent before prescribing or dispensing a prescription drug that is not included on a preferred drug list or that is subject to special access or reimbursement restrictions.

History: Add. 2004, Act 248, Imd. Eff. July 23, 2004.

Popular name: Act 280

400.109i Locally or regionally based single point of entry agencies for long-term care.

Sec. 109i. (1) The director of the department of community health shall designate and maintain locally or regionally based single point of entry agencies for long-term care that shall serve as visible and effective access points for individuals seeking long-term care and that shall promote consumer choice and quality in long-term care options.

(2) The department of community health shall monitor single point of entry agencies for long-term care to assure, at a minimum, all of the following:

(a) That bias in functional and financial eligibility determination or assistance and the promotion of specific services to the detriment of consumer choice and control does not occur.

(b) That consumer assessments and support plans are completed in a timely, consistent, and quality manner through a person-centered planning process and adhere to other criteria established by this section and the department of community health.

(c) The provision of quality assistance and supports.

(d) That quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.

(e) Consumer access to an independent consumer advocate.

(f) That data and outcome measures are being collected and reported as required under this act and by contract.

(g) That consumers are able to choose their supports coordinator.

(3) The department of community health shall establish and publicize a toll-free telephone number for areas of the state in which a single point of entry agency is operational as a means of access.

(4) The department of community health shall require that single point of entry agencies for long-term care perform the following duties and responsibilities:

(a) Provide consumers and any others with unbiased information promoting consumer choice for all long-term care options, services, and supports.

(b) Facilitate movement between supports, services, and settings in a timely manner that assures consumers' informed choice, health, and welfare.

(c) Assess consumers' eligibility for all medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.

(d) Assist consumers in obtaining a financial determination of eligibility for publicly funded long-term care programs.

(e) Assist consumers in developing their long-term care support plans through a person-centered planning process.

(f) Authorize access to medicaid programs for which the consumer is eligible and that are identified in the consumer's long-term care supports plan. The single point of entry agency for long-term care shall not refuse to authorize access to medicaid programs for which the consumer is eligible.

(g) Upon request of a consumer, his or her guardian, or his or her authorized representative, facilitate

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needed transition services for consumers living in long-term care settings if those consumers are eligible for those services according to a policy bulletin approved by the department of community health.

(h) Work with designated representatives of acute and primary care settings, facility settings, and community settings to assure that consumers in those settings are presented with information regarding the full array of long-term care options.

(i) Reevaluate the consumer's eligibility and need for long-term care services upon request of the consumer, his or her guardian, or his or her authorized representative or according to the consumer's long-term care support plan.

(j) Except as otherwise provided in subdivisions (k) and (*l*), provide the following services within the prescribed time frames:

(*i*) Perform an initial evaluation for long-term care within 2 business days after contact by the consumer, his or her guardian, or his or her authorized representative.

(*ii*) Develop a preliminary long-term care support plan in partnership with the consumer and, if applicable, his or her guardian or authorized representative within 2 business days after the consumer is found to be eligible for services.

(*iii*) Complete a final evaluation and assessment within 10 business days from initial contact with the consumer, his or her guardian, or his or her authorized representative.

(k) For a consumer who is in an urgent or emergent situation, within 24 hours after contact is made by the consumer, his or her guardian, or his or her authorized representative, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian or authorized representative.

(*l*) Except as provided in subsection (20), for a consumer who receives notice that within 72 hours he or she will be discharged from a hospital, within 24 hours after contact is made by the consumer, his or her guardian, his or her authorized representative, or the hospital discharge planner, perform an initial evaluation and develop a preliminary long-term care support plan. The preliminary long-term care support plan shall be developed in partnership with the consumer and, if applicable, his or her guardian, his or her authorized representative, or the hospital discharge planner.

(m) Initiate contact with and be a resource to hospitals within the area serviced by the single point of entry agencies for long-term care.

(n) Provide consumers with information on how to contact an independent consumer advocate and a description of the advocate's mission. This information shall be provided in a publication prepared by the department of community health in consultation with these entities. This information shall also be posted in the office of a single point of entry agency.

(o) Collect and report data and outcome measures as required by the department of community health, including, but not limited to, the following data:

(*i*) The number of referrals by level of care setting.

(*ii*) The number of cases in which the care setting chosen by the consumer resulted in costs exceeding the costs that would have been incurred had the consumer chosen to receive care in a nursing home.

(*iii*) The number of cases in which admission to a long-term care facility was denied and the reasons for denial.

(*iv*) The number of cases in which a memorandum of understanding was required.

(*v*) The rates and causes of hospitalization.

(*vi*) The rates of nursing home admissions.

(*vii*) The number of consumers transitioned out of nursing homes.

(*viii*) The average time frame for case management review.

(*ix*) The total number of contacts and consumers served.

(*x*) The data necessary for the completion of the cost-benefit analysis required under subsection (11).

(*xi*) The number and types of referrals made.

(*xii*) The number and types of referrals that were not able to be made and the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

(p) Maintain consumer contact information and long-term care support plans in a confidential and secure manner.

(q) Provide consumers with a copy of their preliminary and final long-term care support plans and any updates to the long-term care plans.

(5) The department of community health, in consultation with the office of long-term care supports and services, the Michigan long-term care supports and services advisory commission, the department, and the

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office of services to the aging, shall promulgate rules to establish criteria for designating local or regional single point of entry agencies for long-term care that meet all of the following criteria:

(a) The designated single point of entry agency for long-term care does not provide direct or contracted medicaid services. For the purposes of this section, the services required to be provided under subsection (4) are not considered medicaid services.

(b) The designated single point of entry agency for long-term care is free from all legal and financial conflicts of interest with providers of medicaid services.

(c) The designated single point of entry agency for long-term care is capable of serving as the focal point for all individuals, regardless of age, seeking information about long-term care in their region, including individuals who will pay privately for services.

(d) The designated single point of entry agency for long-term care is capable of performing required consumer data collection, management, and reporting.

(e) The designated single point of entry agency for long-term care has quality standards, improvement methods, and procedures in place that measure consumer satisfaction and monitor consumer outcomes.

(f) The designated single point of entry agency for long-term care has knowledge of the federal and state statutes and regulations governing long-term care settings.

(g) The designated single point of entry agency for long-term care maintains an internal and external appeal process that provides for a review of individual decisions.

(h) The designated single point of entry agency for long-term care is capable of delivering single point of entry services in a timely manner according to standards established by the department of community health and as prescribed in subsection (4).

(6) A single point of entry agency for long-term care that fails to meet the criteria described in this section or other fiscal and performance standards prescribed by contract and subsection (7) or that intentionally and knowingly presents biased information that is intended to steer consumer choice to particular long-term care supports and services is subject to disciplinary action by the department of community health. Disciplinary action may include, but is not limited to, increased monitoring by the department of community health, additional reporting, termination as a designated single point of entry agency by the department of community health, or any other action as provided in the contract for a single point of entry agency.

(7) Fiscal and performance standards for a single point of entry agency include, but are not limited to, all of the following:

(a) Maintaining administrative costs that are reasonable, as determined by the department of community health, in relation to spending per client.

(b) Identifying savings in the annual state medicaid budget or limits in the rate of growth of the annual state medicaid budget attributable to providing services under subsection (4) to consumers in need of long-term care services and supports, taking into consideration medicaid caseload and appropriations.

(c) Consumer satisfaction with services provided under subsection (4).

(d) Timeliness of delivery of services provided under subsection (4).

(e) Quality, accessibility, and availability of services provided under subsection (4).

(f) Completing and submitting required reporting and paperwork.

(g) Number of consumers served.

(h) Number and type of long-term care services and supports referrals made.

(i) Number and type of long-term care services and supports referrals not completed, taking into consideration the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

(8) The department of community health shall develop standard cost reporting methods as a basis for conducting cost analyses and comparisons across all publicly funded long-term care systems and shall require single point of entry agencies to utilize these and other compatible data collection and reporting mechanisms.

(9) The department of community health shall solicit proposals from entities seeking designation as a single point of entry agency and, except as provided in subsection (16) and section 109j, shall initially designate not more than 4 agencies to serve as a single point of entry agency in at least 4 separate areas of the state. There shall not be more than 1 single point of entry agency in each designated area. An agency designated by the department of community health under this subsection shall serve as a single point of entry agency for an initial period of up to 3 years, subject to the provisions of subsection (6). In accordance with subsection (17), the department shall require that a consumer residing in an area served by a single point of entry agency designated under this subsection utilize that agency if the consumer is seeking eligibility for medicaid long-term care programs.

(10) The department of community health shall evaluate the performance of single point of entry agencies under this section on an annual basis.

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(11) The department of community health shall engage a qualified objective independent agency to conduct a cost-benefit analysis of single point of entry, including, but not limited to, the impact on medicaid long-term care costs. The cost-benefit analysis required in this subsection shall include an analysis of the cost to hospitals when there is a delay in a patient's discharge from a hospital due to the hospital's compliance with the provisions of this section.

(12) The department of community health shall make a summary of the annual evaluation, any report or recommendation for improvement regarding the single point of entry, and the cost-benefit analysis available to the legislature and the public.

(13) Not earlier than 12 months after but not later than 24 months after the implementation of the single point of entry agency designated under subsection (9), the department of community health shall submit a written report to the senate and house of representatives standing committees dealing with long-term care issues, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on community health, and the senate and house fiscal agencies regarding the array of services provided by the designated single point of entry agencies and the cost, efficiencies, and effectiveness of single point of entry. In the report required under this subsection, the department of community health shall provide recommendations regarding the continuation, changes, or cancellation of single point of entry agencies based on data provided under subsections (4) and (10) to (12).

(14) Beginning in the year the report is submitted and annually after that, the department of community health shall make a presentation on the status of single point of entry and on the summary information and recommendations required under subsection (12) to the senate and house of representatives appropriations subcommittees on community health to ensure that legislative review of single point of entry shall be part of the annual state budget development process.

(15) The department of community health shall promulgate rules to implement this section not later than 270 days after submitting the report required in subsection (13).

(16) The department of community health shall not designate more than the initial 4 agencies designated under subsection (9) to serve as single point of entry agencies or agencies similar to single point of entry agencies unless all of the following occur:

(a) The written report is submitted as provided under subsection (13).

(b) Twelve months have passed since the submission of the written report required under subsection (13).

(c) The legislature appropriates funds to support the designation of additional single point of entry agencies.

(17) A single point of entry agency for long-term care shall serve as the sole agency within the designated single point of entry area to assess a consumer's eligibility for medicaid long-term care programs utilizing a comprehensive level of care assessment approved by the department of community health.

(18) Although a community mental health services program may serve as a single point of entry agency to provide services to individuals with mental illness or developmental disability, community mental health services programs are not subject to the provisions of this act.

(19) Medicaid reimbursement for health facilities or agencies shall not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the 4 pilot single point of entry agencies designated under subsection (9).

(20) The provisions of this section and section 109j do not apply after December 31, 2011.

(21) Funding for the MI Choice Waiver program shall not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the 4 pilot single point of entry agencies designated under subsection (9).

(22) A single point of entry agency for long-term care may establish a memorandum of understanding with any hospital within its designated area that allows the single point of entry agency for long-term care to recognize and utilize an initial evaluation and preliminary long-term care support plan developed by the hospital discharge planner if those plans were developed with the consumer, his or her guardian, or his or her authorized representative.

(23) For the purposes of this section:

(a) "Administrative costs" means the costs that are used to pay for employee salaries not directly related to care planning and supports coordination and administrative expenses necessary to operate each single point of entry agency.

(b) "Administrative expenses" means the costs associated with the following general administrative functions:

(*i*) Financial management, including, but not limited to, accounting, budgeting, and audit preparation and response.

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(*ii*) Personnel management and payroll administration.

(*iii*) Purchase of goods and services required for administrative activities of the single point of entry agency, including, but not limited to, the following goods and services:

(A) Utilities.

(B) Office supplies and equipment.

(C) Information technology.

(D) Data reporting systems.

(E) Postage.

(F) Mortgage, rent, lease, and maintenance of building and office space.

(G) Travel costs not directly related to consumer services.

(H) Routine legal costs related to the operation of the single point of entry agency.

(c) "Authorized representative" means a person empowered by the consumer by written authorization to act on the consumer's behalf to work with the single point of entry, in accordance with this act.

(d) "Guardian" means an individual who is appointed under section 5306 of the estates and protected individuals code, 1998 PA 386, MCL 700.5306. Guardian includes an individual who is appointed as the guardian of a minor under section 5202 or 5204 of the estates and protected individuals code, 1998 PA 386, MCL 700.5202 and 700.5204, or who is appointed as a guardian under the mental health code, 1974 PA 258, MCL 300.1001 to 300.2106.

(e) "Informed choice" means that the consumer is presented with complete and unbiased information on his or her long-term care options, including, but not limited to, the benefits, shortcomings, and potential consequences of those options, upon which he or she can base his or her decision.

(f) "Person-centered planning" means a process for planning and supporting the consumer receiving services that builds on the individual's capacity to engage in activities that promote community life and that honors the consumer's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the consumer desires or requires.

(g) "Single point of entry" means a program from which a current or potential long-term care consumer can obtain long-term care information, screening, assessment of need, care planning, supports coordination, and referral to appropriate long-term care supports and services.

(h) "Single point of entry agency" means the organization designated by the department of community health to provide case management functions for consumers in need of long-term care services within a designated single point of entry area.

History: Add. 2006, Act 634, Imd. Eff. Jan. 4, 2007.

Popular name: Act 280

400.109j Designation of single point of entry agencies; limitation.

Sec. 109j. The department of community health shall not designate more than the initial 4 agencies designated under section 109i(9) to serve as single point of entry agencies or agencies similar to single point of entry agencies unless the conditions of section 109i(16) are met and the legislature repeals this section.

History: Add. 2006, Act 634, Imd. Eff. Jan. 4, 2007.

Popular name: Act 280

400.109k Compliance of certain community mental health services programs with MCL 330.1204 and 330.1205.

Sec. 109k. Effective October 1, 2013, a community mental health services program established by a single charter county that has situated totally within that county a city having a population of at least 500,000 shall comply with sections 204(4) and 205 of the mental health code, 1974 PA 258, MCL 330.1204 and 330.1205, before contracting with the department of community health as a specialty prepaid health plan to provide specialty services and supports.

History: Add. 2012, Act 375, Eff. Mar. 28, 2013.

400.109l Process for maximum allowable cost pricing reconsiderations; use by department of community health and contracted health plans; completion; notification to pharmacy.

Sec. 109*l*. The department of community health and contracted health plans shall utilize a process for maximum allowable cost pricing reconsiderations that must be available and provided to providers and pharmacists. This process must include identification of 3 national drug codes, if there are 3 or more available, and all available national drug codes, if there are fewer than 3, for the drug in question that are actually available and deliverable by a Michigan licensed wholesaler or a Michigan licensed manufacturer and would fall into the department of community health's or contracted health plans' maximum allowable cost

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pricing. The process must be completed in 10 business days, with all notification to the pharmacy in either written or electronic form. The department of community health and contracted health plans cannot be held accountable for failing to provide information for which they do not have access.

History: Add. 2014, Act 167, Eff. Mar. 31, 2015.

400.109m Individual as victim of human trafficking violation; medical assistance benefits; "human trafficking violation" defined.

Sec. 109m. (1) If an individual is a victim of a human trafficking violation, he or she may receive medical assistance benefits for medical and psychological treatment resulting from his or her status as a victim of that human trafficking violation.

(2) As used in this section, "human trafficking violation" means a violation of chapter LXVIIA of the Michigan penal code, 1931 PA 328, MCL 750.462a to 750.462h.

History: Add. 2014, Act 341, Eff. Jan. 14, 2015.

Popular name: Act 280

400.110 Medical services for residents absent from state.

Sec. 110. Services under this act may be provided to a resident of this state who is temporarily absent from the state. Out of state physicians and institutions in which service is received shall be licensed or approved by the appropriate standard-setting authority in the other state.

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967.

Popular name: Act 280

400.110a Funding; rural hospital access pool; limitations; definitions.

Sec. 110a. (1) Beginning in the fiscal year that ends September 30, 2019, and annually after that, the department shall allocate not less than $26,000,000.00 of its general fund appropriation to a rural hospital access pool to assist sole community hospitals, critical access hospitals, and rural hospitals with providing services to low-income residents.

(2) All of the following apply to a payment from the rural hospital access pool:

(a) $7,978,300.00 shall be proportionately divided annually among sole community hospitals and rural hospitals that provide obstetrical care to Medicaid beneficiaries, based on the proportion of Medicaid deliveries performed during the second immediately preceding fiscal year.

(b) The balance remaining in the rural hospital access pool after distribution made under subdivision (a) shall be annually allocated as follows:

(*i*) Payments shall first be allocated to reimburse sole community hospitals, critical access hospitals, and rural hospitals for unreimbursed and incurred costs for services delivered to fee for service inpatient and outpatient Medicaid beneficiaries as reported during the second immediately preceding fiscal year cost reporting period.

(*ii*) Money remaining in the rural hospital access pool after all distributions are made under subparagraph (*i*) shall be allocated based on each sole community hospital's, critical access hospital's, and rural hospital's proportion of Medicaid managed care outpatient payments for services performed during the second immediately preceding fiscal year.

(c) Notwithstanding subdivisions (a) and (b), no hospital shall receive more than 10% of the total funding available under the rural hospital access pool in any 1 fiscal year.

(3) The department must implement this section in a manner that complies with all federal requirements necessary to ensure the maximum amount of federal matching funds is obtained.

(4) As used in this section:

(a) "Critical access hospital" means a hospital designated and certified as a critical access hospital under 42 CFR 485.606.

(b) "Medicaid" means the medical assistance administered by the department under this act.

(c) "Rural hospital" means a hospital that meets both of the following:

(*i*) Has 50 or fewer staffed beds.

(*ii*) Is located within a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 15,000 based on the 2010 federal decennial census.

(d) "Sole community hospital" means a hospital classified as a sole community hospital under 42 CFR 412.92.

History: Add. 2018, Act 220, Eff. Sept. 24, 2018.

Popular name: Act 280

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400.111 Responsibility for proper handling of medical case; actions authorized to meet medical needs of recipient.

Sec. 111. (1) The state department is responsible for the proper handling of each medical case. The state department may transfer a recipient to some other medical institution for treatment better adapted to the recipient's needs, or take any other action to insure meeting the medical needs of the recipient.

(2) When the director has issued an order under section 111f or taken an action authorized by section 111d(1)(b) or (c) with respect to a residential health care facility, that is a hospital, nursing home, or other institution reimbursed for residential or patient care by the medical assistance program established pursuant to this act, the director shall discharge the responsibility under subsection (1) by doing 1 or more of the following:

(a) Arranging for a transfer authorized by subsection (1) and for payment for care rendered until the date of transfer.

(b) Requesting the director of the department of public health to take appropriate action under Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(c) Filing a petition with the circuit court to place the residential health care facility under the control of a receiver.

(d) Arranging, with the agreement of the affected provider, for the deposit of payments for care rendered a recipient by the residential health care facility in an escrow account.

(e) Using other appropriate means, which shall include assuring that payment is made for care rendered a recipient, that conform with state and federal law, regulation, and policy.

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1980, Act 321, Imd. Eff. Dec. 12, 1980.

Popular name: Act 280

Administrative rules: R 330.11001 et seq. of the Michigan Administrative Code.

400.111a Policy and procedures for implementation and enforcement of state and federal laws; consultation; guidelines; forms and instructions; "prudent buyer" defined; criteria for selection of providers; notice of change in policy, procedure, form, or instruction; power of director; informal conference; imposition of specific conditions and controls; notice; hearings; examination of claims; imposition of claims review process; books and records of provider; confidentiality; immunity from liability; prohibited payments or recovery for payments; making payments and collecting overpayments; development of specifications; estimated cost and charge information; notice to provider of incorrect payment.

Sec. 111a. (1) The director of the department of community health, after appropriate consultation with affected providers and the medical care advisory council established according to federal regulations, may establish policies and procedures that he or she considers appropriate, relating to the conditions of participation and requirements for providers established by section 111b and to applicable federal law and regulations, to assure that the implementation and enforcement of state and federal laws are all of the following:

(a) Reasonable, fair, effective, and efficient.

(b) In conformance with law.

(c) In conformance with the state plan for medical assistance adopted under section 10 and approved by the United States department of health and human services.

(2) The consultation required by this section shall be conducted in accordance with guidelines adopted by the state department of community health according to section 24 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.224.

(3) Except as otherwise provided in section 111i, the director of the department of community health shall develop, after appropriate consultation with affected providers in accordance with guidelines, forms and instructions to be used in administering the program. Forms developed by the director of the department of community health shall be, to the extent administratively feasible, compatible with forms providers are required to file with 1 or more other third party payers or with 1 or more regulatory agencies and, to the extent administratively feasible, shall be designed to facilitate use of a single form to satisfy requirements imposed on providers by more than 1 payer, agency, or other entity. The forms and instructions shall relate, at a minimum, to standards of performance by providers, conditions of participation, methods of review of claims, and administrative requirements and procedures that the director of the department of community health

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considers reasonable and proper to assure all of the following:

(a) That claims against the program are timely, substantiated, and not false, misleading, or deceptive.

(b) That reimbursement is made for only medically appropriate services.

(c) That reimbursement is made for only covered services.

(d) That reimbursement is not made to those providers whose services, supplies, or equipment cost the program in excess of the reasonable value received.

(e) That the state is a prudent buyer.

(f) That access and availability of services to the medically indigent are reasonable.

(4) As used in subsection (3), "prudent buyer" means a purchaser who does 1 or more of the following:

(a) Buys from only those providers of services, supplies, or equipment to medically indigent individuals whose performance, in terms of quality, quantity, cost, setting, and location is appropriate to the specific needs of those individuals, and who, in the case of providers who receive payment on the basis of costs, comply with the prudent buyer concept of titles XVIII and XIX.

(b) Pays for only those services, supplies, or equipment that are needed or appropriate.

(c) Seeks to economize by minimizing cost.

(5) The director of the department of community health shall select providers to participate in arrangements such as case management, in supervision of services for recipients who misutilize or abuse the medical services program, and in special projects for the delivery of medical services to eligible recipients. Providers shall be selected based upon criteria that may include a comparison of services and related costs with those of the provider's peers and a review of previous participation warnings or sanctions undertaken against the provider or the provider's employer, employees, related business entities, or others who have a relationship to the provider, by the medicaid, medicare, or other health-related programs. The director of the department of community health may consult with the appropriate peer review advisory committees as appointed by the department of community health.

(6) The director of the department of community health shall give notice to each provider of a change in a policy, procedure, form, or instruction established or developed under this section that affects the provider. For a change that affects 1 or more types of providers, a departmental bulletin or updating insert to a departmental manual mailed 30 days before the effective date of the change shall constitute sufficient notice. The department of community health may provide notice required under this subsection via United States mail or electronic mail.

(7) The director of the department of community health may do all of the following:

(a) Enroll in the program for medical assistance only a provider who has entered into an agreement of enrollment required by section 111b(4), and enter into an agreement only with a provider who satisfies the conditions of participation and requirements for a provider established by sections 111b and 111i and the administrative requirements established or developed under subsections (1), (2), and (3) with the appropriate consultation required by this section.

(b) Enforce the requirements established under this act by applying the procedures of sections 111c to 111f. If in these procedures the director of the department of community health is required to consult with professionals or experts before first utilizing these individuals in the program, the director of the department of community health shall have given the opportunity to review their professional credentials to the appropriate medicaid peer review advisory committee.

(c) Except as otherwise provided in section 111i, develop with the appropriate consultation required by this section and require the form or format for claims, applications, certifications, or certifications and recertifications of medical necessity required by section 108, and develop specifications for and require supporting documentation that is compatible with the approved state medical assistance plan under title XIX.

(d) Recover payments to a provider in excess of the reimbursement to which the provider is entitled. The department of community health shall have a priority lien on any assets of a provider for any overpayment, as a consequence of fraud or abuse, that is not reimbursed to the department of community health.

(e) Notwithstanding any other provisions of this act, before payment of claims, identify for examination for compliance with the program of medical assistance, including but not limited to medical necessity, the claims submitted by a particular provider based upon a determination that the provider's claims for disputed services exceed the average program dollar amount or volume of the same type of services, submitted by the same type of provider, performed in the same setting, and submitted during the same period. In order to carry out the authority conferred by this subdivision, the director of the department of community health shall notify the provider in the form of registered mail, receipted by the addressee, or by proof of service to the provider, or representative of the provider, of the state department of community health's intent to impose specific conditions and controls before authorizing payment for specific claims for services. The notice shall contain all of the following:

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(*i*) A list of the particular practice or practices disputed by the state department of community health and a factual description of the nature of the dispute.

(*ii*) A request for specific medical records and any other relevant supporting information that fully discloses the basis and extent to which the disputed practice or practices were rendered.

(*iii*) A date certain for an informal conference between the provider or representative of the provider and the state department of community health to resolve the differences surrounding the disputed practice or practices.

(*iv*) A statement that unless the provider or representative of the provider demonstrates at the informal conference that the disputed practice or practices are medically necessary, or are in compliance with other program coverages, specific conditions and controls may be imposed on future payments for the disputed practice or practices, and claims may be rejected, beginning on the sixteenth day after delivery of this notice.

(8) For any provider who is subject to a notice of intent to impose specific conditions and controls before authorizing payment for specific claims for services, as specified in subsection (7)(e), the state department of community health shall afford that provider an opportunity for an informal conference before the sixteenth day after delivery of the notice under subsection (7)(e). If the provider fails to appear at the conference, or fails to demonstrate that the disputed practice or practices are medically necessary or are in compliance with program coverages, the state department of community health beginning on the sixteenth day following receipt of notice by the provider, is authorized to impose specific conditions and controls before payment for the disputed practice or practices and may reject claims for payments for the practice or practices. The state department of community health, within 5 days following the informal conference, shall notify the provider of its decision regarding the imposition of special conditions and controls before payment for the disputed practice or practices. Upon the imposition of specific conditions and controls before payment, the provider upon request shall be entitled to an immediate hearing held in conformity with chapter 4 and chapter 6 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.287 and 24.301 to 24.306, if any of the following occurs:

(a) The claim for services rendered is not paid within 30 days of the provider's compliance with the conditions imposed.

(b) The claim is rejected.

(c) The provider notifies the state department of community health by registered mail that the provider does not intend to comply with the specific conditions and controls imposed, and the claim for services rendered is not paid within 30 days after delivery of this notice.

(9) The hearing provided for under subsection (8) shall be conducted in a prompt and expeditious manner. At the hearing, the provider may contest the state department of community health's decision to impose specific conditions and controls before payment. Subsequent hearings may be conducted at the provider's request only if the claims have not been considered at a prior hearing and reflect issues that also have not been considered at a prior hearing, or if a claim for services rendered is not paid within 60 days after the provider's compliance with the conditions imposed.

(10) The authority conferred in subsection (8) with respect to the claims submitted by a particular provider does not prohibit the state department of community health from examining claims or portions of claims before payment of the claims to determine their compliance with the program of medical assistance, in compliance with law. The director of the department of community health may take additional action under subsection (8) during the pendency of an appeal taken under subsection (8).

(11) If in the department of community health's opinion, the provider shifts his or her claims from the disputed services addressed under subsection (7)(e) to other claims that fall under the purview of subsection (7)(e), the director of the department of community health may impose the claims review process of this section immediately upon delivery of the notice of that imposition to the provider as provided in subsection (7)(e).

(12) If in the department of community health's opinion, claims similar to the disputed services addressed under subsection (7)(e) are shifted to another provider in the same corporation, partnership, clinic, provider group, or to another provider in the employ of the same employer or contractor, the director of the department of community health may impose the claims review process of this section immediately upon delivery of notice of that imposition to the new provider as provided in subsection (7)(e). The department of community health shall afford the new provider an opportunity for an immediate informal conference within 7 days under subsection (8) after the initiation of the claims process.

(13) The director of the department of community health may request a provider to open books and records in accordance with section 111b(7) and may photocopy, at the state department of community health's expense, the records of a medically indigent individual. The records shall be confidential, and the state department shall use the records only for purposes directly and specifically related to the administration of the

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program. The immunity from liability of a provider subject to the director of the department of community health's authority under this subsection is governed by section 111b(7).

(14) The director of the department of community health shall not pay for services, supplies, or equipment furnished by a provider, or shall recover for payment made, during a period in which the provider does not have on file with the state department of community health disclosure forms as required by section 111b(19).

(15) The director of the department of community health shall make payments to, and collect overpayments from, the provider, unless the provider and the provider's employer satisfy the conditions prescribed in section 111b(25), (26), and (27), in which case the director of the department of community health may make payments directly to, and collect overpayments from, the provider's employer.

(16) The director of the department of community health, with the appropriate consultation required by this section, may develop specifications for and require estimated cost and charge information to be submitted by a provider under section 111b(13) and the form or format for submission of the information.

(17) If the director of the department of community health decides that a payment under the program has been made to which a provider is not or may not be entitled, or that the amount of a payment is or may be greater or less than the amount to which the provider is entitled, the director of the department of community health, except as otherwise provided in this subsection or under other applicable law or regulation, shall promptly notify the provider of this decision. The director of the department of community health shall withhold notification to the provider of the decision upon advice from the department of attorney general or other state or federal enforcement agency in a case where action by the department of attorney general or other state or federal enforcement agency may be compromised by the notification. If the director of the department of community health notifies a provider of a decision that the provider has received an underpayment, the state department of community health shall reimburse the provider, either directly or through an adjustment of payments, in the amount found to be due.

History: Add. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1982, Act 461, Imd. Eff. Dec. 30, 1982;—Am. 1986, Act 227, Eff. Nov. 1, 1986;—Am. 2000, Act 187, Imd. Eff. June 20, 2000;—Am. 2012, Act 472, Imd. Eff. Dec. 27, 2012.

Popular name: Act 280

400.111b Requirements as condition of participation by provider.

Sec. 111b. (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).

(2) A provider shall comply with all licensing and registration laws of this state applicable to the provider's practice or business. For a facility that is periodically inspected by a licensing authority, maintenance of licensure constitutes compliance.

(3) A provider shall be certified, if the provider is of the type for which certification is required by title XVIII or XIX.

(4) A provider shall enter into an agreement of enrollment specified by the director.

(5) A provider who renders a reimbursable service described in section 109 to a medically indigent individual shall provide the individual with service of the same scope and quality as would be provided to the general public.

(6) A provider shall maintain records necessary to document fully the extent and cost of services, supplies, or equipment provided to a medically indigent individual and to substantiate each claim and, in accordance with professionally accepted standards, the medical necessity, appropriateness, and quality of service rendered for which a claim is made.

(7) Upon request and at a reasonable time and place, a provider shall make available any record required to be maintained by subsection (6) for examination and photocopying by authorized agents of the director, the department of attorney general, or federal authorities whose duties and functions are related to state programs of medical assistance under title XIX. If a provider releases records in response to a request by the director made under section 111a(13) or in compliance with this subsection, that provider is not civilly liable in damages to a patient or to another provider to whom, respectively, the records relate solely, on account of the response or compliance.

(8) A provider shall retain each record required to be maintained by subsection (6) for a period of 7 years after the date of service. A provider who no longer personally retains the records due to death, retirement, change in ownership, or other reason, shall ensure that a suitable person retains the records and provides access to the records as required in subsection (7).

(9) A provider shall require, as a condition of a contract with a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity, for the purpose of generating billings in the name of the provider or on behalf of the provider to the department, that the person, partnership, corporation, or other entity, its representative, successor, or assignee, retain for not less than 7 years, copies of all documents used

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in the generation of billings, including the certifications required by subsection (17), and, if applicable, computer billing tapes if returned by the department.

(10) A provider shall submit all claims for services rendered under the program on a form or in a format and with the supporting documentation specified and required by the director under section 111a(7)(c) and by the commissioner of insurance under section 111i. Submission of a claim or claims for services rendered under the program does not establish in the provider a right to receive payment from the program.

(11) A provider shall submit initial claims for services rendered within 12 months after the date of service, or within a shorter period that the director may establish or that the commissioner of insurance may establish under section 111i. The director shall not delegate the authority to establish a time period for submission of claims under this subsection. Except as otherwise provided in section 111i, the director, with the consultation required by section 111a, may prescribe the conditions under which a provider may qualify for a waiver of the time period established under this subsection with respect to a particular submission of a claim. Neither this state nor the medically indigent individual is liable for payment of claims submitted after the period established under this subsection.

(12) A provider shall not charge the state more for a service rendered to a medically indigent individual than the provider's customary charge to the general public or another third party payer for the same or similar service.

(13) A provider shall submit information on estimated costs and charges on a form or in a format and at times that the director may specify and require according to section 111a(16).

(14) Except for copayment authorized by the department and in conformance with applicable state and federal law, a provider shall accept payment from the state as payment in full by the medically indigent individual for services received. A provider shall not seek payment from the medically indigent individual, the family, or representative of the individual for either of the following:

(a) Authorized services provided and reimbursed under the program.

(b) Services determined to be medically unnecessary in accordance with professionally accepted standards.

(15) A provider may seek payment from a medically indigent individual for services not covered nor reimbursed by the program if the individual elected to receive the services with the knowledge that the services would not be covered nor reimbursed under the program.

(16) A provider promptly shall notify the director of a payment received by the provider to which the provider is not entitled or that exceeds the amount to which the provider is entitled. If the provider makes or should have made notification under this subsection or receives notification of overpayment under section 111a(17), the provider shall repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayment in the manner required by the director. Failure to repay, return, restore, or reimburse the overpayment or a consistent pattern of failure to notify the director shall constitute a conversion of the money by the provider.

(17) As a condition of payment for services rendered to a medically indigent individual, a provider shall certify that a claim for payment is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information. A provider is responsible for the ongoing supervision of an agent, officer, or employee who prepares or submits the provider's claims. A provider's certification required under this subsection shall be prima facie evidence that the provider knows that the claim or claims are true, accurate, prepared with his or her knowledge and consent, do not contain misleading or deceptive information, and are filed in compliance with the policies, procedures, and instructions, and on the forms established or developed under this act. Certification shall be made in the following manner:

(a) For an invoice or other prescribed form submitted directly to the department by the provider in claim for payment for the provision of services, by an indelible mark made by hand, mechanical or electronic device, stamp, or other means by the provider, or an agent, officer, or employee of the provider.

(b) For an invoice or other form submitted in claim for payment for the provision of services submitted indirectly by the provider to the department through a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity that generates and files claims on a provider's behalf, by the indelible written name of the provider on a certification form developed by the director for submission to the department with each group of invoices or forms in claim for payment. The certification form shall indicate the name of the person, if other than the provider, who signed the provider's name.

(c) For a warrant issued in payment of a claim submitted by a provider, by the handwritten indelible signature of the payee, if the payee is a natural person; by the handwritten indelible signature of an officer, if the payee is a corporation; or by handwritten indelible signature of a partner, if the payee is a partnership.

(18) A provider shall comply with all requirements established under section 111a(1), (2), and (3).

(19) A provider shall file with the department, on disclosure forms provided by the director, a complete and truthful statement of all of the following:

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(a) The identity of each individual having, directly or indirectly, an ownership or beneficial interest in a partnership, corporation, organization, or other legal entity, except a company registered according to the securities exchange act of 1934, 15 USC 78a to 78nn, through which the provider engages in practice or does business related to claims or charges against the program. This subdivision does not apply to a health facility or agency that is required to comply with and has complied with the disclosure requirements of section 20142(3) of the public health code, 1978 PA 368, MCL 333.20142. With respect to a company registered under the securities exchange act of 1934, 15 USC 78a to 78nn, a provider shall disclose the identity of each individual having, directly or indirectly, separately or in combination, a 5% or greater ownership or beneficial interest.

(b) The identity of each partnership, corporation, organization, legal entity, or other affiliate whose practice or business is related to a claim or charge against the program in which the provider has, directly or indirectly, an ownership or beneficial interest, trust agreement, or a general or perfected security interest. This subdivision does not apply to a health facility or agency that is required to comply with and has complied with the disclosure requirements of section 20142(4) of the public health code, 1978 PA 368, MCL 333.20142.

(c) If applicable to the provider, a copy of a disclosure form identifying ownership and controlling interests submitted to the United States department of health and human services in fulfillment of a condition of participation in programs established according to title V, XVIII, XIX, and XX. To the extent that information disclosed on this form duplicates information required to be filed under subdivision (a) or (b), filing a copy of the form shall satisfy the requirements under those subdivisions.

(20) If requested by the director, a provider shall supply complete and truthful information as to his or her professional qualifications and training, and his or her licensure in each jurisdiction in which the provider is licensed or authorized to practice.

(21) In the interest of review and control of utilization of services, a provider shall identify each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim submitted to the department.

(22) It is the obligation of a provider to assure that services, supplies, or equipment provided to, ordered, or prescribed on behalf of a medically indigent individual by that provider will meet professionally accepted standards for the medical necessity, appropriateness, and quality of health care.

(23) If any service, supply, or equipment provided directly by a provider, or any service, supply, or equipment prescribed or ordered by a provider and delivered by someone other than that provider, is determined not to be medically necessary, not appropriate, or not otherwise in accordance with medical assistance program coverages, the provider who directly provided, ordered, or prescribed the service, supply, or equipment is responsible for direct and complete repayment of any program payment made to the provider or to any other person for that service, supply, or equipment. Services, supplies, or equipment provided by a consulting provider based upon his or her independent evaluation or assessment of the recipient's needs is the responsibility of the consulting provider. This subsection does not apply to repayment by a provider who has ordered a nursing home or hospital admission of the service billed by and reimbursed to a nursing home or hospital. This section also does not apply to a nursing home or hospital unless the nursing home or hospital acted on its own initiative in providing the service, supply, or equipment as opposed to following the order or prescription of another.

(24) A provider shall satisfy or make acceptable arrangement to satisfy all previous adjudicated program liabilities including those adjudicated according to section 111c or established by agreement between the department and the provider, and restitution ordered by a court. As used in this subsection, provider includes, but is not limited to, the provider, the provider's corporation, partnership, business associates, employees, clinic, laboratory, provider group, or successors and assignees. For a nursing home or hospital, "business associates", as used in this subsection, means those persons whose identity is required to be disclosed under section 20142(3) of the public health code, 1978 PA 368, MCL 333.20142.

(25) A provider who is a physician, dentist, or other individual practitioner shall file with the department a complete and factual disclosure of the identity of each employer or contractor to whom the provider is required to submit, in whole or in part, payment for services provided to a medically indigent individual as a condition of the provider's agreement of employment or other agreement. A provider who has properly disclosed the required information by filing a form or forms has 30 business days in which to report changes in the list of identified individuals and entities. The disclosure required by this subsection may serve as the provider's authorization for the department to make direct payments to the employer.

(26) As a condition of receiving payment for services rendered to a medically indigent individual, a provider may enter, as an employee, into agreements of employment of the type described in subsection (25) only with an employer who has entered into an agreement as described in subsection (27).

(27) An employer described in subsection (25) shall enter into an agreement on a form prescribed by the

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department, in which, as a condition of directly receiving payment for services provided by its employee provider to a medically indigent individual, the employer agrees to all of the following:

(a) To require as a condition of employment that the employee provider submit, in whole or in part, payments received for services provided to medically indigent individuals.

(b) To advise the department within 30 days after any changes in the employment relationship.

(c) To comply with the conditions of participation established by this subsection and subsections (6) to (19) and (21).

(d) To agree to be jointly and severally responsible with the employee provider for any overpayments resulting from the department's direct payment under this section.

(e) To agree that disputed claims relative to overpayments shall be adjudicated in administrative proceedings convened under section 111c.

(28) If a provider who is a nursing home intends to withdraw from participation in the title XIX program, the provider shall notify the department in writing. The provider shall continue to participate in the title XIX program for each patient who was admitted to the nursing home before the date notice is given under this subsection and who is or may become eligible to receive medical assistance under this act.

(29) A provider shall protect, maintain, retain, and dispose of patient medical records and other individually identifying information in accordance with subsection (6), any other applicable state or federal law, and the most recent provider agreement.

(30) At a minimum, if a provider is authorized to dispose of patient records or other patient identifying information, including records required by subsection (6), the provider shall ensure that medical records that identify a patient and other individually identifying information are sufficiently deleted, shredded, incinerated, or disposed of in a fashion that will protect the confidentiality of the patient's health care information and personal information. The department may take action to enforce this subsection. If the department cannot enforce compliance with this subsection, the department may enter into a contract or make other arrangements to ensure that patient records and other individually identifying information are disposed of in a fashion that will protect the confidentiality of the patient's health care information and personal information and assess costs associated with that disposal against the provider. The provider's responsibilities with regard to maintenance, retention, and disposal of patient medical records and other individually identifying information continue after the provider ceases to participate in the medical assistance program for the time period specified under this section.

History: Add. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1982, Act 461, Imd. Eff. Dec. 30, 1982;—Am. 1986, Act 227, Eff. Nov. 1, 1986;—Am. 1994, Act 74, Imd. Eff. Apr. 11, 1994;—Am. 2000, Act 187, Imd. Eff. June 20, 2000;—Am. 2006, Act 575, Imd. Eff. Jan. 3, 2007.

Popular name: Act 280

400.111c Duties of director in carrying out authority conferred by MCL 400.111a(7)(d).

Sec. 111c. (1) To carry out the authority conferred by section 111a(7)(d), the director shall do 1 or more of the following:

(a) Accept an assurance of repayment of amounts alleged to be due to the state department. The assurance shall not constitute an admission of guilt nor be introduced in any other civil or criminal proceeding. The assurance may include a stipulation for either of the following:

(*i*) The voluntary payment to the state department by the provider of the amount alleged to be due to the state department.

(*ii*) The voluntary payment, to an aggrieved medically indigent individual specified by the director, by the provider of the amount alleged to be due to the medically indigent individual.

(b) Hold or institute a hearing in conformity with chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws. The presiding officer at a hearing shall determine if an amount is due the state and shall include the determination in his or her proposal for decision. Except as provided in section 111f(4), the director shall not delegate the authority to make a final decision in a contested case under this subdivision. A hearing shall be concluded not later than 90 days after being commenced, unless otherwise agreed upon by the department and the provider or providers. The proposal for decision shall be rendered not later than 45 days after the hearing is concluded. Exceptions may be filed not later than 10 days after the date of mailing the proposal for decision. The director shall render a final decision not later than 15 days after the date of closure for the filing of exceptions. The final decision in a contested case under this subdivision may contain an order directing payment of an amount found to be due the state. The final decision may order immediate payment of the entire amount or may allow the provider a period of time which is reasonable under the circumstances to pay the state. The order shall specify the period of time allowed and a rate of interest,

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equal to the current rate being earned by the state treasurer's common cash fund, to be paid by the provider during that time regardless of the method of payment. The interest shall be computed from the date of the overpayment notice, but shall not be applied to medicaid interim payment overpayments. Upon the provider's failure to comply with the order in a timely manner, the director shall request the department of attorney general to petition a court of competent jurisdiction to enforce the order. Failure to appeal the final order within 30 days after receipt of a copy of the order shall foreclose the provider from collateral attack against the order or any underlying determination.

(c) Hold an informal meeting, as provided in this section, with the provider or authorized representative of the provider, after giving written notice to the provider. The purpose of an informal meeting is to offer the provider the opportunity to be heard and to negotiate a withholding of an amount, pending an administrative hearing and final decision on the merits pursuant to chapters 4 and 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws. The amount withheld shall not be more than the ratio of overpayment to the total paid volume from present and future medical assistance payments based on billings submitted by the provider, and shall be deposited into an interest-bearing escrow account. If the provider and the state department are unable to reach a negotiated withheld amount by the commencement of the hearing on the merits pursuant to subsection (1)(a)(*i*), the state department shall withhold an amount equal to not more than 25% of the present and future payments. This subdivision shall not be applied with respect to a nursing home or a hospital. The agreement shall not constitute an admission of guilt nor be introduced in any other civil or criminal proceeding. If both parties agree as to a disposition of the state department's claim, the state department shall cancel the scheduled administrative hearing. The following procedure shall be complied with regardless of any agreement on the amount to be withheld pending the outcome of the hearing:

(*i*) The dates of an informal meeting and of the administrative hearing shall be set forth in the notification to the provider that alleges excess payments have been received. That notification shall be in the form of registered mail, receipted by the addressee, or by proof of service to the provider or representative of the provider.

(*ii*) An informal meeting shall be concluded not later than 35 calendar days after the date of notification to the provider, and the administrative hearing shall be scheduled for the forty-fifth calendar day from the date of notification. The director shall have the administrative hearing convened on the forty-fifth day regardless of the cause on the part of either party for delay in concluding the informal meeting within 36 calendar days.

(*iii*) If the withholding of an amount has not been agreed upon by the time of the start of an administrative hearing on the merits, the state department may seek a withholding from present and future payment from billings submitted by the provider of not more than 25% of such payments. The withholding shall be in effect for the pendency of the hearing on the merits and until a decision on the merits. The provider shall have the opportunity to respond to the state department's withholding request. The state department's showing and the decision of the administrative law judge shall be based on all of the following criteria, with each reason stated individually in the opinion:

(A) A showing based upon specific stated facts that probable cause exists that reimbursement in excess of the reimbursement to which provider is entitled has occurred.

(B) A showing that the reimbursement cited in subparagraph (*iii*)(A) amounts to a specific percentage of payments made, as characterized by a statistically valid audit.

(C) A showing that 1 or more services of the same type included in the case, for which the state department is seeking a withholding of funds, has occurred at least once during the most recent 2 calendar quarters prior to the date of notice to the provider.

(*iv*) Any finding of an administrative law judge providing for withholding shall be in effect unless modified by the administrative law judge until the director's final decision on the case. If the administrative law judge rules that an amount shall be withheld from the provider, those funds shall be placed in an interest bearing escrow account. If the final ruling by the administrative law judge determines an amount is due to the state department, and that amount is less than the amount withheld, the provider shall be awarded the difference and proportionate interest of the funds held in escrow.

(*v*) The hearing shall be on the merits of the claim of the state department or provider, or both, and shall be concluded not later than 90 days after being commenced unless otherwise agreed upon by the department and the provider or providers. The administrative law judge shall render a proposal for decision on the merits of the department's claim not later than 90 days after conclusion of the hearing, and shall advise both parties that exceptions may be filed with the administrative law judge not later than 15 days after the date of mailing the proposal for decision.

(*vi*) The director shall make a final decision not later than 15 days after the date of closure for the filing of exceptions, and shall not delegate authority to make a final decision in a contested case under this section.

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The final decision in a contested case under this section shall contain an order directing payment of an amount found to be due to the state or the provider. The final decision may order immediate payment of the entire amount or may allow the provider a period of time which is reasonable under the circumstances to pay the state. The order shall specify the manner of payment, including the period of time allowed and a rate of interest equal to the current rate being earned by the state treasurer's common cash fund to be paid by the provider on all repayments other than the interest bearing withheld amount, to be computed from the date of the notification issued pursuant to this section. Upon the provider's failure to timely comply with the order, the director shall request the attorney general to petition a court of competent jurisdiction to enforce the order. Failure to appeal the final order within 30 days after receipt of a copy of the order shall foreclose the provider from collateral attack against the order or any underlying determination.

(*vii*) If the foregoing means are not adequate to secure recovery of payments, the director shall do 1 or more of the following:

(A) File as a creditor in insolvency proceedings.

(B) Initiate emergency action pursuant to section 111f.

(C) Bring an action for other legal or equitable relief in a court of competent jurisdiction, including, but not limited to, an order to increase, for cause, the 25% withholding limit, an injunction to prevent the removal of attachable assets, an order to sequester assets, or an order for the appointment of a receiver to take possession of attachable assets.

(2) For purposes of this section, "provider" includes an employer who has executed an agreement conforming to section 111(b)(27).

History: Add. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1982, Act 461, Imd. Eff. Dec. 30, 1982;—Am. 1986, Act 227, Eff. Nov. 1, 1986.

Popular name: Act 280

400.111d Participation as provider subject to denial, suspension, termination, or probation; actions of director; claims precluded; exceptions; consultations; hearing.

Sec. 111d. (1) Participation as a provider in the program is subject to denial, suspension, termination, or probation on the grounds specified by section 111e. The director may take 1 or more of the following actions:

(a) Refuse to enroll an applicant.

(b) Suspend a provider indefinitely or for a term certain.

(c) Terminate the agreement with and the participation of a provider.

(d) Place a provider on probation. At the director's discretion, the probation may have conditions reasonably related to the grounds for probation.

(e) Impose specific limits, conditions, or controls on a provider's provision of services to medically indigent individuals, including specific reviews, documentation, or prior approval of a treatment plan which shall be accomplished before the designated services are rendered.

(f) Selectively suspend a provider's participation at 1 or more practice locations where that provider has no direct, indirect, or close family ownership interest in the practice.

(2) Suspension or termination of a provider shall preclude that provider from submitting a claim, either personally or by a sole proprietorship, clinic, group, partnership, corporation, association, or other entity to the program for any services, supplies, or equipment provided under the program, except for services, supplies, or equipment actually provided and received by a medically indigent individual before the effective date of the suspension or termination.

(3) In reaching a decision whether to exercise authority conferred by this section whenever questions of medical necessity or appropriateness of treatment are involved, the director shall consult, in order to formulate an appropriate action or to evaluate the professional performance of a provider, with peer review advisory committees, professionals, or experts who are individuals of the same licensed profession as the provider subject to the action, as selected by the director.

(4) The affected provider shall be entitled to a hearing held in conformity with chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, on an action proposed to be taken pursuant to this section.

History: Add. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1982, Act 461, Imd. Eff. Dec. 30, 1982;—Am. 1986, Act 227, Eff. Nov. 1, 1986.

Popular name: Act 280

400.111e Grounds for action by director.

Sec. 111e. (1) The grounds for action by the director under section 111d(1) and the actions to which they

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may be applied shall be as follows:

(a) The director may take action under section 111d(1)(a), (b), (c), (d), or (f) for a provider's failure to disclose the information required by section 111b(7), (19), or (25).

(b) The director may take action under section 111d(1)(a) for a provider's failure to properly apply for enrollment and to submit documentation specified by the director under section 111a(7)(c).

(c) The director may take action under section 111d(1)(b), (c), or (f) for a provider's failure to furnish proper certification to the director pursuant to section 111b(17), or for a provider's failure to comply with section 111b(26), or for a provider's failure to comply with, or attempt to circumvent, section 111a(7)(e).

(d) The director may take action under section 111d(1)(a), (b), (c), (d), (e), or (f) for a provider's failure to conform to professionally accepted standards of medical practice.

(e) The director may take action under section 111d(1)(a), (b), (c), (d), or (f) for an employer's failure to comply with section 111b(27).

(f) The director may take action under section 111d(1)(a), (b), (c), or (f) for a provider's failure to comply with section 111b(1), (2), (3), or (4).

(2) The director shall take action under section 111d(1)(a) or (c) if any of the following occurs:

(a) The provider is convicted of violating the medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.

(b) The provider is convicted of, or pleads guilty to, a criminal offense or attempted criminal offense relating to the provider's practice of health care in any jurisdiction.

(c) The provider continues, or reinitiates, a pattern of practice for which the provider was sanctioned previously under this act. For purposes of this subdivision, "sanction" means those actions prescribed in sections 111a(7)(d) and 111d(1)(a) to (f).

(d) The provider dispenses, renders, or provides services, supplies, or equipment without a practitioner's prescription or order.

(e) The provider attempts to circumvent or fails to comply with section 111b(7).

(f) The provider is suspended or terminated as a provider from participation in the medicaid or medicare program, or other governmentally supported program in any jurisdiction.

(3) The director shall take action under section 111d(1)(a), (b), (c),(d), or (f) if any of the following occurs:

(a) The provider continues to submit duplicate claims for services, supplies, or equipment for which the provider has already received reimbursement from any source after receiving notice from the department to stop submitting duplicate claims; or the provider receives reimbursement from any other source after receiving medicaid payment and does not refund the appropriate portion of the medicaid payment to the department.

(b) The provider submits a claim for services, supplies, or equipment that was not provided to a recipient.

(c) The provider submits a claim for services, supplies, or equipment that includes costs or charges not related to those services, supplies, or equipment actually provided to the recipient.

(d) The provider continues to submit claims for services, supplies, or equipment, or continues to refer recipients to another provider by referral, order, or prescription for services, supplies, or equipment, which are not documented in the record in the prescribed manner, are medically inappropriate or medically unnecessary, or are below the acceptable medical treatment standards, after receiving notice from the department to cease that practice. This subdivision does not apply to a nursing home or hospital unless the nursing home or hospital acted on its own initiative in providing the service, supply, or equipment as opposed to following the order or prescription of another.

(e) The provider continues to submit claims that misrepresent the description of services, supplies, or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing, or referring practitioner; or the identity of the actual provider, after receiving notice from the state department to cease the practice. As used in this subdivision, "misrepresentation" does not include the submission of a claim in compliance with specific written policies and procedures issued by the state department and approved by the director or the director's designee.

(f) The provider submits a claim for which the documentation in a patient's medical record or chart contains misleading or inaccurate information regarding the diagnosis, treatment, or cause of a patient's condition; or the documentation in a patient's medical record or chart has been altered or destroyed so that an ongoing audit or overpayment action cannot adequately be pursued by the department.

(g) The provider fails to complete the required fields on the claim form or fails to provide required information related to the claim after receiving notice from the department to complete the required fields or to provide the required information.

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(h) The provider submits a claim for reimbursement for services, or equipment for a fee or charge that is higher than the provider's usual, customary charge to the general public for the same services, supplies, or equipment.

(i) The provider submits a claim for services, supplies, or equipment that was not rendered by the provider.

(j) The provider is serving a sentence in a correctional facility.

(4) A provider subject to an action or proposed action by the director under this section shall be entitled to a hearing held in conformity with chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws.

(5) In addition to or in place of the grounds specified in subsection (1), (2), or (3), the director may base an action provided for in section 111d(1)(a), (b), (c), (d), (e), or (f) on his or her judgment that the action is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

(6) Any individual against whom an enrollment sanction has been levied under this section shall not participate directly or indirectly in the medicaid program during the pendency of the enrollment sanction.

(7) The director may reinstate the participation in the medical services program of an individual against whom an enrollment sanction has been levied under this section if the director makes a determination that the reinstatement is in the best interests of the medical services program and the medical care of recipients.

History: Add. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1986, Act 227, Eff. Nov. 1, 1986.

Popular name: Act 280

400.111f Emergency action; order; circumstances; extension of emergency action; "most recent 12-month period" defined; consultation with peer review advisory committees, professionals, or experts; order for summary suspension of payments; hearings; decision; meeting not required.

Sec. 111f. (1) The director may issue an order incorporating a finding that emergency action is required to protect the state's interest, as the state's interest is described in this subsection by the statement of circumstances warranting emergency action, in any of the following: the public health, welfare, or safety; medically indigent individuals; or public funds of the program of medical assistance. Circumstances that warrant emergency action include, but are not limited to, any of the following:

(a) A reasonable belief, determined in accordance with professionally accepted standards, that rendered services for which a provider has submitted claims were medically unnecessary, inappropriate, or of inferior quality, and therefore that the continued participation in the program by the provider or payments to the provider for services constitutes a threat to the public health, safety, or welfare or to the health, safety, or welfare of recipient medically indigent individuals.

(b) A reasonable belief that the provider has violated the medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.

(c) A reasonable belief that the overpayment sought to be recovered pursuant to this section, or pursuant to any other section of this act, is in jeopardy of not being recovered.

(d) A reasonable belief that 10% or $10,000.00, whichever is less, for a noninstitutional provider, or 10% or $50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period was unsubstantiated or was for services that were noncovered.

(e) A reasonable belief that 10% or $10,000.00, whichever is less, for a noninstitutional provider, or 10% or $50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period were medically unnecessary, inappropriate, or of inferior quality.

(f) A reasonable belief that 15% or $15,000.00, whichever is less, for a noninstitutional provider, or 15% or $75,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during a consecutive 12-month period, and that 5% or $5,000.00, whichever is less, for a noninstitutional provider, or 5% or $25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were noncovered.

(g) A reasonable belief that 15% or $15,000.00, whichever is less, for a noninstitutional provider, or 15% or $75,000.00, whichever is less, for an institutional provider, of the provider's claims submitted at any time

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during a consecutive 12-month period, and that 5% or $5,000.00, whichever is less, for a noninstitutional provider, or 5% or $25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were medically unnecessary, inappropriate, or of inferior quality.

(h) A reasonable belief that the provider is refusing to comply with section 111b(7), (19), or (25).

(2) If the director finds that emergency action is required under subsection (1) in a clinic, corporation, partnership, or other entity with multiple providers or locations, the director may extend any emergency action to the entire legal entity and its providers.

(3) As used in subsection (1), "most recent 12-month period" means a period of not more than 12 consecutive months within the 15 consecutive months immediately preceding the notice to the provider that an emergency action has been taken.

(4) In order to determine whether the conditions described in subsection (1)(a), (d), (e), (f), or (g) exist, the director shall consult with peer review advisory committees, professionals, or experts who are individuals of the same licensed profession as the provider subject to the action, as selected by the director.

(5) Upon a determination that circumstances described in subsection (1) exist, the director may issue an order for the summary suspension of payments on pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in the program of medical assistance. The summary suspension shall be effective on the date specified in the order or on service of a certified copy of the order on the provider, whichever occurs later, and shall remain in effect during administrative or judicial proceedings on the suspension. Upon request of a provider, a contested case hearing pursuant to chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, shall be commenced not later than 15 days after the summary suspension. If a contested case hearing is requested by a provider relative to an emergency suspension under this section, a hearing shall be held to determine whether the emergency suspension is supported by competent, material, and substantial evidence on the whole record. Under appropriate circumstances, the state department may hold or institute a hearing under section 111c(1), or take an action under section 111d at the same time an action is taken under this section, while an action under this section is pending, or after a decision on an action is made. The presiding officer may consolidate the 2 hearings into a single proceeding in the interest of economy. However, the director shall not make a final decision in a contested case under section 111c(1) or 111d arising from or related to an emergency action or the circumstances upon which an emergency action was taken.

(6) A hearing, conference, or similar meeting between a provider or representative of a provider and the state department shall not be required to be held or conducted before the emergency suspension of payment to the provider or the emergency suspension of participation of the provider in the program of medical assistance under this section.

History: Add. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1982, Act 461, Imd. Eff. Dec. 30, 1982;—Am. 1986, Act 227, Eff. Nov. 1, 1986.

Popular name: Act 280

400.111g Prosecution not collaterally estopped or barred by decision or order; hearing; decision.

Sec. 111g. (1) Notwithstanding any provision in this act, a decision or order of the state department, the director, or any other person rendering a decision in an administrative hearing under this act shall not operate to collaterally estop or bar the prosecution of a person for a violation of this act or a violation of any other statute or common law.

(2) Except as otherwise provided in this act, if a hearing is commenced to determine the validity of any action taken by the state department under this act, the decision in the hearing once concluded shall be rendered promptly but not more than 30 days after the date of conclusion of the hearing.

History: Add. 1982, Act 461, Imd. Eff. Dec. 30, 1982.

Popular name: Act 280

400.111h Applicability of MCL 400.111a to 400.111g.

Sec. 111h. Sections 111a to 111g shall not apply to a provider of medical services under this act if that provider is required by federal or state law, regulation, or directive to accept medicaid recipients.

History: Add. 1986, Act 227, Eff. Nov. 1, 1986.

Popular name: Act 280

400.111i Timely claims processing and payment procedure; external review; report;

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definitions.

Sec. 111i. (1) The commissioner of office of financial and insurance services shall establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing for, and qualified health plans in processing and paying claims for, medicaid services rendered. The commissioner shall consult with the department of community health, health professionals and facilities, and qualified health plans in establishing this timely payment procedure.

(2) The timely claims processing and payment procedure established by the commissioner under subsection (1) shall provide for all of the following:

(a) That a "clean claim", for the purposes of this section, means a claim that does at a minimum all of the following:

(*i*) Identifies the health professional or health facility that provided treatment or service, including a matching identifying number.

(*ii*) Identifies the patient and plan.

(*iii*) Lists the date and place of service.

(*iv*) Is for covered services.

(*v*) Is certified pursuant to section 111b(17) and has the identifying information required under section 111b(21).

(*vi*) If necessary, substantiates the medical necessity and appropriateness of the care or service provided.

(*vii*) If prior authorization is required for certain patient care or services, includes any applicable authorization number, as appropriate.

(*viii*) Includes additional documentation based upon services rendered as reasonably required by the payer.

(b) A universal system of coding to be used on all medicaid claims submitted to qualified health plans.

(c) That a claim must be transmitted electronically or as otherwise specified by the commissioner and a qualified health plan must be able to receive a claim transmitted electronically.

(d) That a health professional and facility must bill a qualified health plan within 1 year after the date of service or date of discharge from the health facility.

(e) That after a health professional or facility has submitted a claim to a qualified health plan, the health professional or facility shall not resubmit the same claim to the qualified health plan unless the time frame in subdivision (f) has passed or as provided in subdivision (h).

(f) Except as otherwise provided in this subdivision, that a clean claim must be paid within 45 days after receipt of the claim by the qualified health plan. For a pharmaceutical clean claim, the clean claim must be paid within the industry standard time frame for paying the claim as of the effective date of this subdivision or within 45 days after receipt of the claim by the qualified health plan, whichever is sooner. A clean claim that is not paid within this time frame shall bear simple interest at a rate of 12% per annum.

(g) That a qualified health plan must state in writing to the health professional or facility any defect in the claim within 30 days after receipt of the claim.

(h) That 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 qualified health plan shall pay the claim within 30 days after the defect is corrected.

(i) That a qualified health plan must notify the health professional or facility and the commissioner of the defect if a claim or a portion of a claim is returned from a health professional or facility under subdivision (h) and remains defective for the original reason or a new reason.

(j) An external review procedure for adverse determinations of payment as provided in subsections (4) and (5). The costs for the external review procedure shall be assessed as determined by the commissioner.

(k) Penalties to be applied to health professionals, health facilities, and qualified health plans for failing to adhere to the timely claims processing and payment procedure established under this section.

(*l*) A system for notifying the licensing entity for health maintenance organizations, qualified health plans, and other health care insurers if a penalty is incurred under subdivision (k).

(3) If a qualified health plan determines that 1 or more covered services listed on a claim are payable, the qualified health plan shall pay for those services and shall not deny the entire claim because 1 or more other covered services listed on the claim are defective or because 1 or more other services listed on the claim are not covered services.

(4) The commissioner shall establish an external review procedure as provided in this subsection and subsection (5). A health professional or facility may request an external review by the commissioner of a qualified health plan's adverse determination if the health professional or facility makes the request not later than 30 days after receipt of a notice under subsection (2)(i). Within 10 days after a request for an external review, the commissioner shall complete a preliminary review to determine whether the external review may

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proceed or request more information from the health professional, facility, or the qualified health plan. The health professional, facility, or the qualified health plan shall supply the commissioner with the requested information not later than 10 business days after receipt of the request for information from the commissioner. Not later than 5 business days after receipt of any information requested by the commissioner, the commissioner shall complete a preliminary review to determine whether the external review may proceed. If the commissioner determines the external review may not proceed, the commissioner shall notify in writing the health professional or facility of the specific reasons for the determination and may permit the health professional or facility to reapply for a preliminary review by the commissioner. If the commissioner determines the external review may proceed, the commissioner shall notify in writing the health professional or facility and the qualified health plan and shall require the qualified health plan to provide not later than 7 business days after the notice any information used by the qualified health plan in making the adverse determination. Failure by a health professional or facility or qualified health plan to provide the commissioner with requested information permits the commissioner to terminate a review and issue a decision reversing or affirming an adverse determination.

(5) If the commissioner determines that an external review may proceed, the commissioner shall immediately assign an independent review organization to conduct the external review. Only an independent review organization meeting qualifications established by the commissioner shall be assigned to conduct an external review. The independent review organization may request the health professional or facility and the qualified health plan to provide information and shall review all pertinent information submitted by the health professional or facility and the qualified health plan along with the terms of coverage under the medicaid plan. The independent review organization shall make a written recommendation that includes the rationale and supporting documentation and any recommendation for an assessment of interest to the commissioner not later than 30 days after being assigned as the review organization. The commissioner shall notify in writing the health professional or facility and the qualified health plan of his or her decision reversing or affirming the qualified health plan's adverse determination and shall include the principal reasons for the decision not later than 15 days after receipt of the assigned independent review organization's recommendation. If an adverse determination is reversed, the qualified health plan shall immediately pay the claim and any interest assessed by the commissioner.

(6) Beginning not later than October 1, 2000 and continuing thereafter, the department of community health shall not enter into or renew a contract with a qualified health plan unless the qualified health plan agrees to follow the timely claims processing and payment procedure established under this section and requires health professionals and facilities under contract with the qualified health plan to follow the timely claims processing and payment procedure established under this section. The department of community health shall not enter into or renew a contract with a qualified health plan unless the commissioner determines that the qualified health plan satisfies all of the following:

(a) Is a health maintenance organization licensed or issued a certificate of authority in this state.

(b) Uses standardized claims as outlined in the provider contract and accepts claims submitted electronically in a generally accepted format.

(c) Demonstrates the ability to provide all required or covered medicaid services including covered specialty care to the estimated number of enrollees on a regional basis.

(d) Meets the criteria for delivering the comprehensive package of services under the department of community health's comprehensive health plan.

(7) The commissioner shall report to the senate and house of representatives appropriations subcommittees on community health by October 1, 2001 on the timely claims processing and payment procedure established under this section.

(8) It is not a fraudulent act for a health professional or facility to submit a claim under this section that includes 1 or more rendered services that are determined not covered services.

(9) As used in this section:

(a) “Medicaid” means the program of medical assistance established under section 105.

(b) “Qualified health plan” means, at a minimum, an organization that meets the criteria for delivering the comprehensive package of services under the department of community health's comprehensive health plan.

History: Add. 2000, Act 187, Imd. Eff. June 20, 2000.

Popular name: Act 280

400.111j Prior authorization for medical services or equipment; request by provider; approval or rejection; request for additional information; time period limitations; exception; certain claims not subject to prior authorization; rules; reimbursement system;

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automated payment system; vendor payments; waiver of requirement for prior authorization; automated records; limitation of authorization; definitions.

Sec. 111j. (1) If the director requires prior authorization for any medical services or equipment, a request by a provider for prior authorization shall be approved or rejected within 15 working days after the request is received by the director. If additional information is needed in support of the prior authorization request, the director shall request additional information either verbally or in writing not later than 15 working days after receiving the prior authorization request. Upon receiving the additional information from the provider, the director shall approve or deny the completed prior authorization request not later than 10 working days after receiving the additional information. The time period limitations specified in this subsection shall not apply to prior authorization requests for transplantation and other extraordinary services.

(2) Claims for routine, ordinary medical services or equipment shall not be subject to prior authorization, and claims for medical supplies shall not be subject to prior authorization.

(3) The director, by rule, shall do both of the following:

(a) Prescribe, by category, what information is required from a provider to support a request for prior authorization.

(b) Prescribe which medical services or equipment are subject to prior authorization and list, by category, those medical services or equipment.

(4) The director shall establish a reimbursement system for medical services or equipment receiving prior authorization based upon reasonable cost up to a maximum reimbursement screen of acquiring the medical service or equipment, and shall develop an automated payment system, including at least fee screens and necessary edits. The state department shall make vendor payments through the automated payment system.

(5) The director shall waive the requirement for prior authorization if both of the following conditions exist:

(a) Processing a request for prior authorization will cause an inpatient hospital stay to be prolonged.

(b) The cost of the medical services or equipment is less than the estimated cost of the additional inpatient hospital stay.

(6) The director, not later than 180 days after the effective date of this section, shall maintain and implement automated records of all approved prior authorization requests according to each medical services recipient involved.

(7) This section does not authorize the provision of any medical services, supplies, or equipment that are not otherwise designated to be covered services, supplies, or equipment under this act.

(8) As used in this section, "prior authorization" means a requirement imposed by the director, by which any claim for a particular covered medical service or equipment is payable only if the director's approval for the provision of that service or equipment is given before the service or equipment is furnished.

(9) As used in this section, "by category" means using a categorization system containing at least each of the following categories:

(a) Communication aids.

(b) Hearing aids.

(c) Incontinence supplies.

(d) Orthotic devices.

(e) Ostomy supplies.

(f) Prosthetic devices.

(g) Respiratory equipment.

(h) Seating systems.

(i) Visual aids.

(j) Wheelchairs and mobility aids.

History: Add. 1988, Act 445, Eff. Mar. 30, 1989.

Popular name: Act 280

400.111k Lead screening on children enrolled in medicaid.

Sec. 111k. (1) Beginning October 1, 2007, the department of community health shall ensure that, as a condition of participation and funding, all health professionals, facilities, or health maintenance organizations receiving medicaid payments under this act are in substantial compliance with federal standards for lead screening for children enrolled in medicaid.

(2) The department of community health shall determine the statewide average of lead screening being performed on children who are enrolled in medicaid on October 1, 2007 and shall determine whether the rate of children who are enrolled in medicaid receiving a lead screening is substantially in compliance with the federal standards for lead screening for children enrolled in medicaid. If the rate of children who are enrolled

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in medicaid receiving a lead screening is below 80%, the director of the department of community health shall present to the senate and house health policy committees a written report detailing why the rate is not in substantial compliance with the federally required standards for lead screening and the department of community health's recommendations for improving the rate. If the statewide lead screening testing rate does not equal or exceed 80% for medicaid-enrolled children by October 1, 2007, the department of community health may, with funds appropriated for medicaid managed care or medicaid fee for services, contract with community agencies to provide the percentage of lead screening tests needed to reach an 80% lead screening testing rate. A contracting organization that meets or surpasses contract performance requirements is entitled to share in financial bonuses awarded under the performance bonus program and receive not less than 10% of the beneficiaries who do not voluntarily select a specific health plan at the time of managed care enrollment in addition to any other auto assignments to which the contracting organization is entitled.

(3) As used in this section, “medicaid” means the program of medical assistance administered by the state under section 105.

History: Add. 2004, Act 55, Imd. Eff. Apr. 12, 2004.

Popular name: Act 280

400.111/ Children participants in WIC program; lead testing required.

Sec. 111*l*. Beginning October 1, 2006, the department and the department of community health shall require that all children participants in the special supplemental food program for women, infants, and children (WIC program) receive lead testing. Federal funds provided for administration of the special supplemental food program for women, infants, and children (WIC program) shall not be used to implement or administer the provisions of this section.

History: Add. 2006, Act 286, Imd. Eff. July 19, 2006.

Popular name: Act 280

***** *400.111m.added THIS ADDED SECTION IS EFFECTIVE JUNE 26, 2019* *****

400.111m.added Audit of Medicaid cost reports filed by nursing facility; on-site audit; customer satisfaction survey; availability of documentation; auditor education; annual report.

Sec. 111m. (1) As used in this section and section 111n:

(a) "Audit" means a review of the financial records used to complete a Medicaid cost report for compliance with allowable cost principles and other policy contained in the Medicaid provider manual. Audit includes, but is not limited to, a limited-scope audit or an on-site audit. An audit can be of limited or full scope.

(b) "Completed audit" means issuance of the preliminary summary of audit adjustment notice. Completed audit includes the exit meeting with the nursing facility provider.

(c) "Medicaid cost report" or "cost report" means the cost of care reports submitted annually by a nursing facility that is participating in the Medicaid program at a utilization rate on average of at least 6 Medicaid residents, on department cost reporting forms. A nursing facility provider with less than 6 Medicaid residents per day must file a "less than complete" cost report and is not subject to audit.

(d) "Settlement" means the process of reconciling a nursing facility's interim payments based on filed cost report data to audited cost report data. A final settlement is computed after the cost report has been audited.

(2) The department shall accept a Medicaid cost report filed by a nursing facility not more than 60 calendar days after that nursing facility has filed the cost report.

(3) The department shall ensure that an audit of a Medicaid cost report filed by a nursing facility performed by the department is completed not more than 21 months after the final acceptance of the cost report. The settlement for an audit shall be delivered to the provider not more than 60 calendar days after the provider accepts the final summary of audit adjustments. If a provider fails to release the records necessary to verify a specific cost report expense within 15 business days of a written request from the department, the department may disallow the cost associated with the item in question. The time period described in this subsection does not include time associated with an appeal or a charge of fraud filed against the provider.

(4) An on-site audit may be performed at an individual nursing facility or at the corporate office if a home office cost report is filed. An on-site audit shall not last more than 30 calendar days per cost report year for an individual nursing facility and not more than 180 calendar days per cost report year for more than 6 commonly owned or controlled nursing facilities, unless the nursing facility agrees to an extended timeline. A limited-scope audit shall be performed in the years an on-site audit is not performed. The time periods described in this subsection must be completed within the 21-month time period described in subsection (3).

(5) A customer satisfaction survey shall be provided to the nursing facilities that have completed audits in

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the previous quarter.

(6) A nursing facility shall make available to an auditor documentation required in accordance with the Medicaid state plan, the Medicaid provider manual, and the Code of Federal Regulations relating to Medicare or Medicaid. A nursing facility shall enhance utilization of electronic documents and correspondence to exchange information to reduce time and travel required for nursing facility audits.

(7) If an audit is not completed within 21 months as described in subsection (3), the department shall accept the cost report as filed and move to settlement.

(8) The department shall provide auditor education to ensure consistency in application of department policy. The department shall include an ongoing discussion of all audit adjustments to ensure consistency in applying department policy and shall identify and eliminate any inconsistencies between offices with this training.

(9) Not later than 2 years after the effective date of the amendatory act that added this section, the department must finalize all audits and settlements for cost reports that have been filed since before the effective date of the amendatory act that added this section. A cost report described under this subsection that has not been completed by the department within 2 years of the effective date of the amendatory act that added this section must be accepted by the department as filed by the nursing facility, and a cost report settlement must be issued within 60 calendar days after acceptance.

(10) Beginning 2 years after the effective date of the amendatory act that added this section, the department shall provide an annual report to the appropriate stakeholders, including at least 1 representative from each nursing facility provider trade association, on the implementation and results of the cost report audit and settlement process established under this section. The report shall include, but is not limited to, both of the following:

(a) The number of limited-scope audits, on-site audits, and any other type of audit performed during the reporting period.

(b) Results of the audit satisfaction surveys and how the department has responded to those surveys.

History: Add. 2018, Act 612, Eff. June 26, 2019.

Popular name: Act 280

400.112 Medical services; contract with private agencies as fiscal agents.

Sec. 112. The state department may contract with any private agency, including a corporation or association, to act as fiscal agent in dealing with vendors providing medical service authorized in this act.

History: Add. 1966, Act 321, Eff. Oct. 1, 1966.

Popular name: Act 280

Administrative rules: R 330.11001 et seq. of the Michigan Administrative Code.

400.112a Liability for medicaid services; referral to department of treasury as state debt; claims against tax refund as secondary to claims for child support; "medicaid" defined.

Sec. 112a. (1) An individual is liable to the state for the amount expended by the department under medicaid for medical services for the individual's child if all of the following apply:

(a) The individual is required by court or administrative order to provide dependent health care coverage for the child.

(b) The child is eligible for medicaid.

(c) The individual received payment from a third party for the costs of medical services for the child.

(d) The individual failed to reimburse the provider of the medical services either directly or through the custodial parent or guardian of the child.

(e) The department expended funds under medicaid for the medical services provided for the child.

(2) After notice and an opportunity for an administrative hearing under chapter 4 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws, the department shall refer the matter to the department of treasury for collection as a state debt through the offset of state tax refunds, and may use the services of the department of treasury to levy the salary, wages, or other employment income, of an individual who has a liability to the state pursuant to subsection (1).

(3) Claims against an individual's income or state tax refund under this section are secondary to claims for current and past due child support.

(4) As used in this section, "medicaid" means the program of medical assistance established pursuant to section 105.

History: Add. 1994, Act 429, Imd. Eff. Jan. 6, 1995.

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Popular name: Act 280

400.112b Definitions.

Sec. 112b. As used in this section and sections 112c to 112e:

(a) "Asset disregard" means, with regard to the state's medical assistance program, disregarding any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

(b) "Long-term care insurance policy" means a policy described in chapter 39 of the insurance code of 1956, 1956 PA 218, MCL 500.3901 to 500.3955.

(c) "Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in section 1917(b) of the social security act, 42 USC 1396p.

(d) "Long-term care partnership program policy" means a qualified long-term care insurance policy that the commissioner of the office of financial and insurance services certifies as meeting the requirements of section 1917(b) of the social security act, 42 USC 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(e) "Medicaid" means the program of medical assistance established by the department of community health under section 105.

History: Add. 1995, Act 85, Imd. Eff. June 20, 1995;—Am. 2006, Act 674, Imd. Eff. Jan. 10, 2007.

Popular name: Act 280

400.112c Michigan long-term care partnership program; establishment; purpose; eligibility; reciprocal agreements; consideration of assets; receipt of asset disregard; single point of entry agencies; notice of policy provisions; posting certain information.

Sec. 112c. (1) Subject to subsection (5), the department of community health in conjunction with the office of financial and insurance services and the department of human services shall establish a long-term care partnership program in Michigan to provide for the financing of long-term care through a combination of private insurance and medicaid. It is the intent of the long-term care partnership program to do all of the following:

(a) Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

(b) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under medicaid without first being required to substantially exhaust their resources.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) An individual who is a beneficiary of a Michigan long-term care partnership program policy is eligible for assistance under the state's medical assistance program using the asset disregard as provided under subsection (5).

(3) The department of community health shall pursue reciprocal agreements with other states to extend the asset disregard to Michigan residents who purchased long-term care partnership policies in other states that are compliant with title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(4) Upon diminishment of assets below the anticipated remaining benefits under a long-term care partnership program policy, certain assets of an individual, as provided under subsection (5), shall not be considered when determining any of the following:

(a) Medicaid eligibility.

(b) The amount of any medicaid payment.

(c) Any subsequent recovery by the state of a payment for medical services or long-term care services.

(5) Not later than 270 days after the effective date of the amendatory act that added this subsection, the department of community health shall apply to the United States department of health and human services for an amendment to the state's medicaid state plan to establish that the assets an individual owns and may retain under medicaid and still qualify for benefits under medicaid at the time the individual applies for benefits is increased dollar-for-dollar for each dollar paid out under the individual's long-term care insurance policy if the individual is a beneficiary of a qualified long-term care partnership program policy.

(6) If the long-term care partnership program is discontinued, an individual who purchased a Michigan long-term care partnership program policy before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171.

(7) The department of community health shall contract with the Michigan medicare medicaid assistance

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program or department of community health designated single point of entry agencies, or both, to provide counseling services under the Michigan long-term care partnership program.

(8) The department of community health, in consultation with the department of human services and the office of financial and insurance services, shall develop a notice to consumers detailing in plain language the pertinent provisions of qualified state long-term care insurance partnership policies as they relate to medicaid eligibility and shall determine the appropriate distribution of the notice. The notice shall be available in a printable form on the office of financial and insurance services's website.

(9) The department, the department of community health, and the office of financial and insurance services shall post, on their respective websites, information on how to access the national clearinghouse established under the federal deficit reduction act of 2005, Public Law 109-171, when the national clearinghouse becomes available to consumers.

History: Add. 1995, Act 85, Imd. Eff. June 20, 1995;—Am. 2006, Act 674, Imd. Eff. Jan. 10, 2007.

Popular name: Act 280

400.112d Repealed. 2006, Act 674, Imd. Eff. Jan. 10, 2007.

Compiler's note: The repealed section pertained to requirements relating to a partnership policy.

Popular name: Act 280

400.112e Rules.

Sec. 112e. The department of community health, in consultation with the department of human services and the office of financial services, may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, as necessary to implement the partnership program in accordance with the requirements of section 1917(b) of the social security act, 42 USC 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and applicable federal regulations or guidelines.

History: Add. 1995, Act 85, Imd. Eff. June 20, 1995;—Am. 2006, Act 674, Imd. Eff. Jan. 10, 2007.

Popular name: Act 280

400.112e[1] Payments not required; amounts constituting payment in full.

Sec. 112e. (1) Notwithstanding any other provision of law and through September 30, 1998, the department is not required to pay deductible, coinsurance, or copayment medicare cost-sharing for a service to the extent that the payment, when combined with a payment made under title XVIII for the service, would exceed the payment amount otherwise required under the state plan for the service to be provided to an eligible recipient who is not a medicare beneficiary.

(2) Except for a state plan-approved medical services copayment, the amounts paid by title XVIII and under the state plan for a service, if any, shall constitute payment in full for the service through September 30, 1998.

History: Add. 1997, Act 173, Imd. Eff. Dec. 30, 1997.

Compiler's note: Section 112e, as added by Act 173 of 1997, was compiled as MCL 400.112e[1] to distinguish it from another section 112e, deriving from Act 85 of 1995 and pertaining to rules to implement the partnership program.

Popular name: Act 280

400.112g Michigan medicaid estate recovery program; establishment and operation by department of community health; development of voluntary estate preservation program; report; establishment of estate recovery program; waivers and approvals; duties of department; lien.

Sec. 112g. (1) Subject to section 112c(5), the department of community health shall establish and operate the Michigan medicaid estate recovery program to comply with requirements contained in section 1917 of title XIX. The department of community health shall work with the appropriate state and federal departments and agencies to review options for development of a voluntary estate preservation program. Beginning not later than 180 days after the effective date of the amendatory act that added this section and every 180 days thereafter, the department of community health shall submit a report to the senate and house appropriations subcommittees with jurisdiction over department of community health matters and the senate and house fiscal agencies regarding options for development of the estate preservation program.

(2) The department of community health shall establish an estate recovery program including various estate recovery program activities. These activities shall include, at a minimum, all of the following:

(a) Tracking assets and services of recipients of medical assistance that are subject to estate recovery.

(b) Actions necessary to collect amounts subject to estate recovery for medical services as determined according to subsection (3)(a) provided to recipients identified in subsection (3)(b). Amounts subject to

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recovery shall not exceed the cost of providing the medical services. Any settlements shall take into account the best interests of the state and the spouse and heirs.

(c) Other activities necessary to efficiently and effectively administer the program.

(3) The department of community health shall seek appropriate changes to the Michigan medicaid state plan and shall apply for any necessary waivers and approvals from the federal centers for medicare and medicaid services to implement the Michigan medicaid estate recovery program. The department of community health shall seek approval from the federal centers for medicare and medicaid regarding all of the following:

(a) Which medical services are subject to estate recovery under section 1917(b)(1)(B)(*i*) and (*ii*) of title XIX.

(b) Which recipients of medical assistance are subject to estate recovery under section 1917(a) and (b) of title XIX.

(c) Under what circumstances the program shall pursue recovery from the estates of spouses of recipients of medical assistance who are subject to estate recovery under section 1917(b)(2) of title XIX.

(d) What actions may be taken to obtain funds from the estates of recipients subject to recovery under section 1917 of title XIX, including notice and hearing procedures that may be pursued to contest actions taken under the Michigan medicaid estate recovery program.

(e) Under what circumstances the estates of medical assistance recipients will be exempt from the Michigan medicaid estate recovery program because of a hardship. At the time an individual enrolls in medicaid for long-term care services, the department of community health shall provide to the individual written materials explaining the process for applying for a waiver from estate recovery due to hardship. The department of community health shall develop a definition of hardship according to section 1917(b)(3) of title XIX that includes, but is not limited to, the following:

(*i*) An exemption for the portion of the value of the medical assistance recipient's homestead that is equal to or less than 50% of the average price of a home in the county in which the medicaid recipient's homestead is located as of the date of the medical assistance recipient's death.

(*ii*) An exemption for the portion of an estate that is the primary income-producing asset of survivors, including, but not limited to, a family farm or business.

(*iii*) A rebuttable presumption that no hardship exists if the hardship resulted from estate planning methods under which assets were diverted in order to avoid estate recovery.

(f) The circumstances under which the department of community health may review requests for exemptions and provide exemptions from the Michigan medicaid estate recovery program for cases that do not meet the definition of hardship developed by the department of community health.

(g) Implementing the provisions of section 1396p(b)(3) of title XIX to ensure that the heirs of persons subject to the Michigan medicaid estate recovery program will not be unreasonably harmed by the provisions of this program.

(4) The department of community health shall not seek medicaid estate recovery if the costs of recovery exceed the amount of recovery available or if the recovery is not in the best economic interest of the state.

(5) The department of community health shall not implement a Michigan medicaid estate recovery program until approval by the federal government is obtained.

(6) The department of community health shall not recover assets from the home of a medical assistance recipient if 1 or more of the following individuals are lawfully residing in that home:

(a) The medical assistance recipient's spouse.

(b) The medical assistance recipient's child who is under the age of 21 years, or is blind or permanently and totally disabled as defined in section 1614 of the social security act, 42 USC 1382c.

(c) The medical assistance recipient's caretaker relative who was residing in the medical assistance recipient's home for a period of at least 2 years immediately before the date of the medical assistance recipient's admission to a medical institution and who establishes that he or she provided care that permitted the medical assistance recipient to reside at home rather than in an institution. As used in this subdivision, "caretaker relative" means any relation by blood, marriage, or adoption who is within the fifth degree of kinship to the recipient.

(d) The medical assistance recipient's sibling who has an equity interest in the medical assistance recipient's home and who was residing in the medical assistance recipient's home for a period of at least 1 year immediately before the date of the individual's admission to a medical institution.

(7) The department of community health shall provide written information to individuals seeking medicaid eligibility for long-term care services describing the provisions of the Michigan medicaid estate recovery program, including, but not limited to, a statement that some or all of their estate may be recovered.

(8) The department of community health shall not charge interest on the balance of any Michigan medicaid

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estate recovery payments.

(9) The department of community health shall not place or record a lien on qualifying property under the tax equity and fiscal responsibility act of 1982, Public Law 97-424 (TEFRA).

History: Add. 2007, Act 74, Imd. Eff. Sept. 30, 2007.

Popular name: Act 280

400.112h "Estate" and "property" defined.

Sec. 112h. For the purposes of sections 112g to 112j:

(a) "Estate" means all property and other assets included within an individual's estate that is subject to probate administration under article III of the estates and protected individuals code, 1998 PA 386, MCL 700.3101 to 700.3988, except assets otherwise subject to claims under section 3805(3) of the estates and protected individuals code, 1998 PA 386, MCL 700.3805, are not part of the estate.

(b) "Property" means that term as defined in section 1106 of the estates and protected individuals code, 1998 PA 386, MCL 700.1106.

History: Add. 2007, Act 74, Imd. Eff. Sept. 30, 2007.

Popular name: Act 280

400.112i Use of revenue collected through Michigan Medicaid estate recovery activities; treatment of remaining balances.

Sec. 112i. Revenue collected through Michigan medicaid estate recovery activities shall be used to fund the activities of the Michigan medicaid estate recovery program. Any remaining balances shall be treated as an expenditure credit for long-term care support and services in the medical services appropriation unit of the annual department of community health appropriation.

History: Add. 2007, Act 74, Imd. Eff. Sept. 30, 2007.

Popular name: Act 280

400.112j Rules; report.

Sec. 112j. (1) The department of community health may promulgate rules for the Michigan medicaid estate recovery program according to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(2) Not later than 1 year after implementation of the Michigan medicaid estate recovery program and each year after that, the department of community health shall submit a report to the senate and house appropriations subcommittees with jurisdiction over department of community health matters and the senate and house fiscal agencies regarding the cost to administer the Michigan medicaid estate recovery program and the amounts recovered under the Michigan medicaid estate recovery program.

History: Add. 2007, Act 74, Imd. Eff. Sept. 30, 2007.

Popular name: Act 280

400.112k Applicability of program to certain medical assistance recipients.

Sec. 112k. The Michigan medicaid estate recovery program shall only apply to medical assistance recipients who began receiving medicaid long-term care services after the effective date of the amendatory act that added this section.

History: Add. 2007, Act 74, Imd. Eff. Sept. 30, 2007.

Popular name: Act 280

400.113 “Executive director” and “office” defined.

Sec. 113. As used in sections 113 to 123:

(a) “Executive director” means the director of the office of children and youth services.

(b) “Office” means the office of children and youth services created in section 114.

History: Add. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1972, Act 301, Eff. Jan. 1, 1973;—Am. 1978, Act 87, Eff. Apr. 1, 1978.

Popular name: Act 280

400.114 Office of children and youth services; creation as single purpose entity; duties of office; appointment, duties, and compensation of executive director; rules.

Sec. 114. (1) The office of children and youth services is created as a single purpose entity within the department of social services. The office shall be responsible for the planning, development, implementation, and evaluation of children and youth services conducted, administered, or purchased by the department under the authority of sections 114 to 123.

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(2) The director of social services, after consultation with the governor, shall appoint an executive director of the office. The executive director shall be accountable directly to the director of social services. The executive director shall not be within the classified civil service and shall receive compensation as established by the legislature. The executive director shall:

(a) Represent the department in all matters and hearings pertaining to children and youth services and programs.

(b) Serve as a special advisor to the governor on children and youth services budgets and programs.

(c) Advise the director of social services with respect to children and youth services and programs conducted, administered, or purchased by the department under the authority of sections 114 to 123, and make recommendations to the director for the improvement of those services and programs.

(d) Recommend to the governor and the legislature methods of improving the effectiveness of public and private children and youth services and programs.

(e) Recommend to the governor and the legislature appropriate allocations of public funds for children and youth services and programs.

(3) The department, in conjunction with the office, may promulgate rules necessary to implement, administer, and enforce its powers and duties as described in this act. The rules shall be promulgated pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws.

History: Add. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1972, Act 301, Eff. Jan. 1, 1973;—Am. 1973, Act 189, Imd. Eff. Jan. 8, 1974;—Am. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of equipment, records, and supplies of the office administering the child care fund under former MCL 722.801 et seq. to the office of children and youth services created in this section, see section 2 of Act 87 of 1978.

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

Administrative rules: R 400.1 et seq. of the Michigan Administrative Code.

400.115 Services to children and youth.

Sec. 115. Services to children and youth shall include:

(a) Operating training schools, the children's institute, halfway houses, youth camps, diagnostic centers, state operated regional detention facilities, regional short-term treatment centers, group homes, and other facilities and programs established with the approval of the legislature to provide an effective program of out-of-home care for delinquent or neglected children committed to or placed in the care and custody of the department by probate courts, courts of general criminal jurisdiction, or, where provided by law, the voluntary action of parents or guardians.

(b) Encouraging and assisting in the development and coordination of new programs as well as the coordination of prevailing programs at all levels of government and with those public and private nonprofit agencies and groups providing care or training or supervision for delinquent and neglected children.

(c) Devising and making available a system of supervision for juveniles on conditional release from facilities of the department by establishing departmental programs, or, with the approval of the legislature, by agreement with other units of state, regional, or local government or with private agencies.

(d) Administering grants, subsidies, incentive payments, and other fiscal programs authorized by the legislature including:

(*i*) Subsidies or incentives to insure adequate locally-based probation and other social services for children under the jurisdiction of the juvenile division of the probate court.

(*ii*) Cost-sharing programs between the state and county concerning children's services, including funding prescribed in sections 117c to 117d.

(*iii*) Allocation of funds budgeted to the department for governmental or private organizations operating delinquency prevention programs or projects in accordance with standards established by the office.

(e) Establishing, with the approval of the legislature, training programs for delinquent youth by contract with government and private agencies. The programs may be conducted through camps established by the department or in cooperation with the department of natural resources or with other organizations.

(f) Developing a coordinated system of care for delinquent and neglected children committed to the department. The development of treatment programs and other centers shall be coordinated with locally-operated programs for treatment, detention, and diagnosis.

(g) Gathering and making available statistics and information about the operation of the various state, regional, and local components of the program of neglect and delinquency services and presenting the

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information to the legislature and the public through biennial reports.

(h) Conducting, or causing to be conducted, research necessary to provide effective and adequate children and youth services and programs throughout the state.

(i) Undertaking special studies regarding the development of intensive probation, new probation methods, and other services specifically aimed at reduction of detention and out-of-home care.

(j) Evaluating state statutes, court rules, and funding arrangements related to problems of children and youth and recommending proposals for appropriate changes to insure equity in the availability of services and the protection of the rights of children and youth.

(k) Assisting the legislature in the evaluation of the plan developed under former Act No. 280 of the Public Acts of 1975.

(*l*) Receiving any donation, grant, or gift of money or property without obligation to the state for the benefit of its programs or for children placed with or committed to its care. The office, on receipt of the donation, grant, or gift, shall remit it immediately to the state treasury to be credited to the youth services trust fund which is created in the state treasury.

(m) Services for children and youth authorized in title IV of the social security act, 42 U.S.C. 601 to 603, 604 to 632, 633 to 673, 674 to 679 and in title XX of the social security act, 42 U.S.C. 1397 to 1397e.

History: Add. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1972, Act 301, Eff. Jan. 1, 1973;—Am. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1988, Act 75, Eff. Oct. 1, 1988.

Compiler's note: Act 280 of 1975, referred to in this section, was repealed by Act 296 of 1977.

Section 3 of Act 75 of 1988 provides: "This amendatory act shall take effect June 1, 1988." This section was amended by Act 178 of 1988 to read as follows: "This amendatory act shall take effect October 1, 1988."

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115a Office of children and youth services; duties generally.

Sec. 115a. (1) The office shall:

(a) Establish uniform statewide daily rates for the care of children. In the case of children receiving services by or through child caring agencies licensed pursuant to Act No. 116 of the Public Acts of 1973, as amended, being sections 722.111 to 722.128 of the Michigan Compiled Laws, the daily rates may include an average daily rate for agency supervision. In a case of demonstrated need an exception for payment above the established rate may be obtained through prior written agreement with the office. Standards of care shall be in conformity with Act No. 116 of the Public Acts of 1973, as amended.

(b) Monitor children and youth services and programs operated by or funded through the department.

(c) Establish guidelines for the development of children and youth services and program plans and budgets.

(d) Cooperate with the office of criminal justice programs in the development of the state plan required by Public Law 93-415, 5 U.S.C. 5108; 18 U.S.C. 4351 to 4353, 5031 to 5042; and 42 U.S.C. 3701, 3723, 3733, 3768, 3772 to 3774, 3811 to 3814, 3821, 3882, 3883, 3888, and 5601 to 5751. The office shall review the annual budget of the office of criminal justice programs as that budget relates to juvenile justice services and make recommendations to the governor and the legislature regarding the consistency of the budget with the standards and guidelines recommended by the office.

(e) Coordinate educational and public information programs for the purpose of developing appropriate awareness regarding the problems of children and youth; encourage professional groups to recognize and deal with the problems of children and youth; make information about the problems of children and youth available to organizations dealing with juvenile problems and to the general public; and encourage the development of community programs to improve the status of children and youth.

(f) Enter into contracts necessary for the performance of its powers and duties and the execution of its policies. The contracts may be with a state agency, a local public agency, or a private agency, organization, association, or person to enhance, provide, or improve the availability and quality of children and youth services and programs.

(g) Provide for the administration and supervision of employees of institutions for children and youth operated or maintained by the department.

(h) Develop and allocate the children and youth services budget of the department.

(i) Develop and recommend personnel policies and standards to the director of social services.

(j) Identify and designate priorities to the training needs of employees of the department engaged in the provision of children and youth services programs and participate in the development and implementation of appropriate training programs.

(k) Establish and implement standards of uniform practice for children and youth services programs

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operated by the state, consistent with the rules promulgated under Act No. 116 of the Public Acts of 1973, as amended. The office shall recommend these standards for other public and private child care organizations. The standards shall include provisions for the administration, organization, training, supervision, and funding of children and youth services and programs.

(*l*) Establish and interpret policy for children and youth services administered by the department.

(m) Assist in the development of sound programs and standards for children and youth services and promote programs and policies encouraging the prevention of dependency, neglect, delinquency, and other conditions adversely affecting the welfare of children and youth. These programs and policies shall include services for families of children and youth in trouble or at risk.

(n) Monitor and evaluate children and youth services and programs and recommend to the director of social services and monitor corrective action necessary for the improvement of those services and programs.

(o) Develop and implement standard reporting methods to provide accurate program and statistical data on children and youth affected by children and youth services and programs.

(2) Children and youth services staff allocated to a county shall operate under the supervision and direction of a county director of social services.

(3) Upon the recommendation of the office, the department shall request the attorney general to bring an action in the appropriate court to enforce the terms of an agreement or contract entered into by the office.

History: Add. 1973, Act 154, Imd. Eff. Dec. 6, 1973;—Am. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115b Responsibility for children committed by juvenile division of probate court or court of general criminal jurisdiction; children and youth services and programs; services, actions, and rules as to neglect, exploitation, abuse, cruelty to, or abandonment of children; adoption of nonresident children; investigation; parent fees; policy regarding investigations and foster care service; foster care maintenance payments.

Sec. 115b. (1) The department shall assume responsibility for all children committed to it by the juvenile division of the probate court, the family division of circuit court, or the court of general criminal jurisdiction under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309, and 1935 PA 220, MCL 400.201 to 400.214. The department may provide institutional care, supervision in the community, boarding care, halfway house care, and other children and youth services and programs necessary to meet the needs of those children or may obtain appropriate services from other state agencies, local public agencies, or private agencies, subject to section 115o. If the program of another state agency is considered to best serve the needs of the child, the other state agency shall give priority to the child.

(2) The department shall study and act upon a request for service as to, or a report received of, neglect, exploitation, abuse, cruelty, or abandonment of a child by a parent, guardian, custodian, or person serving in loco parentis, or a report concerning a child in need of protection. On the basis of the findings of the study, the department shall assure, if necessary, the provision of appropriate social services to the child, parent, guardian, custodian, or person serving in loco parentis, to reinforce and supplement the parental capabilities, so that the behavior or situation causing the problem is corrected or the child is otherwise protected. In assuring the provision of services and providing the services, the department shall encourage participation by other existing governmental units or licensed agencies and may contract with those agencies for the purchase of any service within the scope of this subsection. The department shall initiate action in an appropriate court if the conduct of a parent, guardian, or custodian requires. The department shall promulgate rules necessary for implementing the services authorized in this subsection. The rules shall include provision for local citizen participation in the program to assure local understanding, coordination, and cooperative action with other community resources. In the provision of services, there shall be maximum utilization of other public, private, and voluntary resources available within a community.

(3) If an agency or organization proposes to place for adoption, with a person domiciled in this state, a child who is a citizen of or resides in a country other than the United States or Canada, the department shall conduct, within 180 days after receipt of the request from the agency or organization, the investigation prescribed by section 46 of chapter X of the probate code of 1939, 1939 PA 288, MCL 710.46. In a county in which the department determines it to be more feasible both geographically and economically, the department may purchase the adoption services up to the actual cost of providing those services. The department shall charge parent fees prescribed by the legislature.

(4) The office is responsible for the development, interpretation, and dissemination of policy regarding

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departmental investigations requested or ordered by the probate court or the family division of circuit court under section 55(h) and the provision of foster care services authorized by this act. Foster care services shall include foster care of state wards, aid to dependent children foster care, foster care of wards of the family division of circuit court placed under the care and supervision of the department by order of the court, and voluntary parental placement of children in foster care.

(5) All rights to current, past due, and future support payable on behalf of a child committed to or under the supervision of the department and for whom the department is making state or federally funded foster care maintenance payments are assigned to the department while the child is receiving or benefiting from those payments. When the department ceases making foster care maintenance payments for the child, both of the following apply:

(a) Past due support that accrued under the assignment remains assigned to the department.

(b) The assignment of current and future support rights to the department ceases.

(6) The maximum amount of support the department may retain to reimburse the state, the federal government, or both for the cost of care shall not exceed the amount of foster care maintenance payments made from state or federal money, or both.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1988, Act 75, Eff. Oct. 1, 1988;—Am. 1998, Act 516, Imd. Eff. Jan. 12, 1999;—Am. 2004, Act 193, Imd. Eff. July 8, 2004.

Compiler's note: Section 3 of Act 75 of 1988 provides: "This amendatory act shall take effect June 1, 1988." This section was amended by Act 178 of 1988 to read as follows: "This amendatory act shall take effect October 1, 1988."

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115c Placement of children in family homes; approval or disapproval; information; supervision.

Sec. 115c. The office may approve or disapprove the placing of a child in this state in a family home of persons unrelated to the child by a person not a resident of this state or in any family home of this state by an agency or organization which does not have a place of business in this state. Written approval of the proposed placement shall be obtained from the office. The person, agency, or organization shall furnish the office with necessary information regarding the child and the prospective foster parents and a guaranty required by the office to protect the interests of the county in which the child is to be placed. The information shall be forwarded to the county agency of the county in which the prospective home is located, if the judge of probate has given prior general consent to the procedure, or to the director of a licensed child-placing agency, or to an employee of the department who shall investigate the home. If, in the employee's opinion, the placement should be made, the employee shall file an approval with the office. If the proposed placement is or appears to be planned with a view to an adoption of the child under the law of this state by the family with whom the child is to be placed, the prior approval of the proposed placement by the judge of probate of the county of residence of the family is also required. When requested, the office may require supervision of the child in the home until the child is legally adopted or otherwise discharged from care.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115d Plan for establishment, maintenance, and operation of regional facilities to detain children.

Sec. 115d. (1) The office shall develop a plan for the establishment, maintenance, and operation of regional facilities to detain children concerning whom an order of detention has been issued under section 14, 15, or 16 of chapter XIIA of Act No. 288 of the Public Acts of 1939, as amended, being sections 712A.14 to 712A.16 of the Michigan Compiled Laws, or section 27a of chapter IV of the code of criminal procedure, Act No. 175 of the Public Acts of 1927, being section 764.27a of the Michigan Compiled Laws. The primary focus of the plan shall be on providing a service network to areas of the state which do not have detention facilities.

(2) The plan shall include:

(a) An assessment of need for secure detention beds, and a proposal for providing and funding the needed beds.

(b) An evaluation of detention alternatives and a proposal for caring for children needing custody while awaiting court hearings.

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(c) Provisions for a transportation network to serve areas at a distance from secure facilities.

(3) The plan shall encourage the use of emergency shelter facilities and alternatives to secure detention where appropriate.

(4) The plan shall provide that the county from which an order of detention is issued by the juvenile division of the probate court or the court of general criminal jurisdiction shall be liable to the state for 50% of the cost of care of the child.

(5) In formulating the plan, the office shall consult with law enforcement agencies, judges of probate and judges of courts of general criminal jurisdiction, public and private agencies which deal with children's services, and other persons concerned with children and youth services.

(6) The plan shall be submitted to the legislature not later than March 31, 1979, and shall be revised annually.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1988, Act 75, Eff. Oct. 1, 1988.

Compiler's note: Section 3 of Act 75 of 1988 provides: "This amendatory act shall take effect June 1, 1988." This section was amended by Act 178 of 1988 to read as follows: "This amendatory act shall take effect October 1, 1988."

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115e Detention home; assumption of administration, operation, and facilities; agreement; state classified service.

Sec. 115e. (1) The department, to the extent of funds appropriated for that purpose, may assume the administration and operation or the administration, operation, and facilities of a detention home established as an agency of the probate court under section 16 of chapter 12A of Act No. 288 of the Public Acts of 1939, being section 712A.16 of the Michigan Compiled Laws.

(2) The department shall not assume the administration and operation nor the administration, operation, and facilities of a detention home unless an agreement is made with the county board of commissioners and the presiding judge of the probate court to transfer the administration and operation or the administration, operation, and facilities of the detention home to the department.

(3) The department may offer persons employed at a detention home transferred pursuant to this section, as of the effective date of the transfer, the opportunity to be employed in the state classified service in accordance with procedures established by the Michigan civil service commission.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

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400.115f Definitions.

Sec. 115f. As used in this section and sections 115g to 115t:

(a) "Adoptee" means the child who is to be adopted or who is adopted.

(b) "Adoption assistance" means a support subsidy or a support subsidy with medical assistance.

(c) "Adoption assistance agreement" means an agreement between the department and an adoptive parent regarding adoption assistance.

(d) "Adoption code" means the Michigan adoption code, chapter X of the probate code of 1939, 1939 PA 288, MCL 710.21 to 710.70.

(e) "Adoptive parent" means the parent or parents who adopt a child under the adoption code.

(f) "Certification" means a determination of eligibility by the department that an adoptee is eligible for a support subsidy or a medical subsidy, or both, or redetermined adoption assistance.

(g) "Child with special needs" means an individual under the age of 18 years for whom the state has determined all of the following:

(*i*) There is a specific judicial finding that the child cannot or should not be returned to the home of the child's parents.

(*ii*) A specific factor or condition, or a combination of factors and conditions, exists before the adoption is finalized so that it is reasonable to conclude that the child cannot be placed with an adoptive parent without providing adoption assistance under this act. The factors or conditions to be considered may include ethnic or family background, age, membership in a minority or sibling group, medical condition, physical, mental, or emotional disability, or length of time the child has been waiting for an adoptive home.

(*iii*) A reasonable but unsuccessful effort was made to place the adoptee with an appropriate adoptive

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parent without providing adoption assistance under this act or a prospective placement is the only placement in the best interest of the child.

(h) "Compact" means the interstate compact on adoption and medical assistance as enacted in sections 115r and 115s.

(i) "Court" means the family division of circuit court.

(j) "Department" means the department of human services.

(k) "Determination of care rate" means a supplemental payment to the standard age appropriate foster care rate that may be justified when extraordinary care or expense is required. The supplemental payment shall be based on 1 or more of the following for which extraordinary care is required of the foster care provider or an extraordinary expense exists:

(*i*) A physically disabled child for whom the foster care provider must provide measurably greater supervision and care.

(*ii*) A child with special psychological or psychiatric needs that require extra time and a measurably greater amount of care and attention by the foster care provider.

(*iii*) A child requiring a special diet that is more expensive than a normal diet and that requires extra time and effort by the foster care provider to obtain and prepare.

(*iv*) A child whose severe acting out or antisocial behavior requires a measurably greater amount of care and attention of the foster care provider.

(*v*) Any other condition for which the department determines that extraordinary care is required of the foster care provider or an extraordinary expense exists.

(*l*) "Foster care" means placement of a child outside the child's parental home under the department's supervision by a court of competent jurisdiction.

(m) "Medical assistance" means the federally aided medical assistance program under title XIX.

(n) "Medical subsidy" means a reimbursement program that assists in paying for services for an adopted child who has an identified physical, mental, or emotional condition that existed, or the cause of which existed, before the adoption is finalized.

(o) "Medical subsidy agreement" means an agreement between the department and an adoptive parent regarding a medical subsidy.

(p) "Nonrecurring adoption expenses" means reasonable and necessary adoption fees, court costs, attorney fees, and other expenses that are directly related to the legal adoption of a child with special needs. Nonrecurring adoption expenses do not include costs or expenses incurred in violation of state or federal law or that have been reimbursed from other sources or funds.

(q) "Other expenses that are directly related to the legal adoption of a child with special needs" means adoption costs incurred by or on behalf of the adoptive parent and for which the adoptive parent carries the ultimate liability for payment, including the adoption study, health and psychological examinations, supervision of the placement before adoption, and transportation and reasonable costs of lodging and food for the child or adoptive parent if necessary to complete the adoption or placement process.

(r) "Party state" means a state that becomes a party to the interstate compact on adoption and medical assistance.

(s) "Placement" means a placement or commitment, including the necessity of removing the child from his or her parental home, as approved by the court under an order of disposition issued under section 2 of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2.

(t) "Redetermined adoption assistance" means a payment as determined by a certification that may be justified when extraordinary care or expense is required for a condition that existed or the cause of which existed before the adoption from foster care was finalized.

(u) "Redetermined adoption assistance agreement" means a written agreement regarding redetermined adoption assistance between the department and the adoptive parent of a child.

(v) "Residence state" means the state in which the child is a resident by virtue of the adoptive parent's residency.

(w) "Standard age appropriate foster care rate" means the approved maintenance payment rate that is paid for a child in foster family care.

(x) "State" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, or a territory or possession of the United States.

(y) "Support subsidy" means payment for support of a child who has been placed for adoption from foster care.

History: Add. 1980, Act 292, Eff. Nov. 18, 1980;—Am. 1992, Act 40, Eff. June 28, 1992;—Am. 1994, Act 238, Eff. July 5, 1994;—

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Am. 1998, Act 22, Imd. Eff. Mar. 12, 1998;—Am. 2002, Act 648, Imd. Eff. Dec. 23, 2002;—Am. 2004, Act 193, Imd. Eff. July 8, 2004;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Compiler's note: Act 288 of 1939, referred to in this section, was repealed by Act 34 of 1952, Act 143 of 1970, Act 543 of 1978, and Act 642 of 1978.

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115g Support subsidy; payment; requirements; determination of amount; maximum amount; form to be signed by adoptive parent; presentment of first offer by adoptive parent; acceptance or counteroffer by department; completion of certification process.

Sec. 115g. (1) The department may pay a support subsidy to an adoptive parent of an adoptee who is placed in the home of the adoptive parent under the adoption code or under the adoption laws of another state or a tribal government, if all of the following requirements are met:

(a) The department has certified that the adoptee is a child with special needs.

(b) Certification is made before the adoptee's eighteenth birthday.

(c) Certification is made and the adoption assistance agreement is signed by the adoptive parent and the department before the adoption is finalized.

(2) The department shall determine eligibility for the support subsidy without regard to the income of the adoptive parent. The maximum amount shall be equal to the rate that the child received in the family foster care placement or the rate the child would have received if he or she had been in a family foster care placement at the time of adoption. This rate includes the determination of care rate that was paid or would have been paid for the adoptee in a family foster care placement, except that the amount shall be increased to reflect increases made in the standard age appropriate foster care rate paid by the department. The department shall not implement policy to limit the maximum amount at an amount less than the family foster care rate, including the determination of care rate, that was paid for the adoptee while the adoptee was in family foster care.

(3) The department shall, on a separate form, require an adoptive parent to sign that he or she either requests or does not request a support subsidy.

(4) The adoptive parent shall present to the department the first offer of the amount requested for the support subsidy. The department may accept the adoptive parent's offer or present a counteroffer to the adoptive parent for the support subsidy. The department shall consider the prospective adoptive parent's requested rate if that requested rate is consistent with the needs of the child being adopted and the prospective adoptive family's circumstances, unless the requested rate exceeds the maximum foster care rate the child is receiving or would receive if placed in a licensed family foster home.

(5) The department shall complete the certification process within 30 days after it receives a request for a support subsidy.

History: Add. 1990, Act 356, Imd. Eff. Dec. 26, 1990;—Am. 1994, Act 238, Eff. July 5, 1994;—Am. 2002, Act 648, Imd. Eff. Dec. 23, 2002;—Am. 2004, Act 193, Imd. Eff. July 8, 2004;—Am. 2009, Act 17, Imd. Eff. Apr. 9, 2009;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.115h Medical subsidy; payment; requirements; prohibited payment; determination of amount; third party payments; waiver of subsection (3); time of request; payment for treatment of mental or emotional condition.

Sec. 115h. (1) Except as provided in subsection (2), the department may pay a medical subsidy as reimbursement for services either to a service provider or to the adoptive parent of an adoptee who is placed for adoption in the home of the adoptive parent under the adoption code or the laws of any other state or a tribal government, if all of the following requirements are met:

(a) The expenses to be covered by the medical subsidy are necessitated by a physical, mental, or emotional condition of the adoptee that existed or the cause of which existed before the adoption petition was filed or certification was established, whichever occurred first.

(b) The adoptee was in foster care at the time the petition for adoption was filed.

(c) Certification was made before the adoptee's eighteenth birthday.

(2) The department shall not pay a medical subsidy to an adoptive parent for providing treatment or

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services to his or her own adopted child.

(3) The department shall determine the amount of the medical subsidy without respect to the income of the adoptive parent or parents. The department shall not pay a medical subsidy until all other available public money and third party payments have been exhausted. For purposes of this subsection, third party payment is available if an adoptive parent has an option, at or after the time of certification, to obtain from the parent's employer health coverage for the child, with or without cost to the adoptive parent. The department may waive this subsection in cases of undue hardship.

(4) The adoptive parent may request a medical subsidy before or after the adoption is finalized. A medical subsidy requested after the adoptee is placed in adoption is effective the date the application request is received by the department if the necessary required documentation is received within 90 calendar days after the date the application is received. In allocating available funding for medical subsidies, the department shall not give preferential treatment to requests that are made before the adoption is finalized, but shall allocate funds based on a child's need for the subsidy.

(5) Payment of a medical subsidy for treatment of a mental or emotional condition is limited to outpatient treatment unless 1 or more of the following apply:

(a) Certification for the medical subsidy was made before the date the adoption was finalized.

(b) The adoptee was placed in foster care by the court before the petition for adoption was filed.

(c) The adoptee was certified for a support subsidy or redetermined adoption assistance.

History: Add. 1994, Act 238, Eff. July 5, 1994;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Popular name: Act 280

400.115i Adoption assistance agreement; redetermined adoption assistance agreement; medical subsidy agreement; copy; modification or discontinuance; legal status, rights, and responsibilities not affected; report.

Sec. 115i. (1) If adoption assistance is to be paid, the department and the adoptive parent shall enter into an adoption assistance agreement that includes all of the following:

(a) The duration of the adoption assistance to be paid.

(b) Notice of potential eligibility for redetermined adoption assistance.

(c) The amount to be paid and, if appropriate, eligibility for medical assistance.

(d) Conditions for continued payment of the adoption assistance as established by statute.

(e) Any services and other assistance to be provided under the adoption assistance agreement.

(f) Provisions to protect the interests of the child in cases in which the adoptive parent moves to another state while the adoption assistance agreement is in effect.

(2) If it is determined that a child is eligible for redetermined adoption assistance under this act, the department and the adoptive parent shall enter into a redetermined adoption assistance agreement that includes all of the following:

(a) The duration of the redetermined adoption assistance to be paid.

(b) The amount of redetermined adoption assistance to be paid.

(c) If appropriate, eligibility for medical assistance.

(d) Conditions for continued payment of the redetermined adoption assistance. Conditions shall be the same as for adoption assistance as established by law.

(e) Any services and other assistance to be provided under the redetermined adoption assistance agreement.

(f) Provisions to protect the interests of the child in cases in which the adoptive parent moves to another state while the redetermined adoption assistance agreement is in effect.

(3) If medical subsidy eligibility is certified, the department and the adoptive parent shall enter into a medical subsidy agreement covering all of the following:

(a) Identification of the physical, mental, or emotional condition covered by the medical subsidy.

(b) The duration of the medical subsidy agreement.

(c) Conditions for continued eligibility for the medical subsidy as established by statute.

(4) The department shall give a copy of the adoption assistance agreement, the redetermined adoption assistance agreement, or medical subsidy agreement to the adoptive parent.

(5) Unless the medical condition of the adoptee no longer exists, or an event described in section 115j has occurred, as indicated in a report filed under subsection (7) or as otherwise determined by the department, the department shall not modify or discontinue a medical subsidy.

(6) An adoption assistance agreement, redetermined adoption assistance agreement, or medical subsidy agreement does not affect the legal status of the adoptee or the legal rights and responsibilities of the adoptive

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parent.

(7) The adoptive parent shall file a report with the department at least once each year as to the location of the adoptee and other matters relating to the continuing eligibility of the adoptee for adoption assistance, redetermined adoption assistance, or a medical subsidy.

History: Add. 1994, Act 238, Eff. July 5, 1994;—Am. 2002, Act 648, Imd. Eff. Dec. 23, 2002;—Am. 2009, Act 17, Imd. Eff. Apr. 9, 2009;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Popular name: Act 280

400.115j Adoption assistance, medical subsidy, or redetermined adoption assistance; extension; continuation.

Sec. 115j. (1) Except as provided in subsections (2) to (5) and section 115t, adoption assistance, a medical subsidy, or redetermined adoption assistance shall continue until 1 of the following occurs:

(a) The adoptee becomes 18 years of age.

(b) The adoptee is emancipated.

(c) The adoptee dies.

(d) The adoption is terminated.

(e) A determination of ineligibility is made by the department.

(2) If sufficient funds are appropriated by the legislature in the department's annual budget, adoption assistance agreements, redetermined adoption assistance agreements, or medical subsidy agreements, may be extended through state funding for an adoptee under 21 years of age if all of the following criteria are met:

(a) The adoptee has not completed high school or a GED program.

(b) The adoptee is regularly attending high school or a GED program or a program for children with disabilities on a full-time basis and is progressing toward achieving a high school diploma, certificate of completion, or GED.

(c) The adoptee is not eligible for supplemental security income.

(3) Adoption assistance agreements may be extended through title IV-E funding for an eligible adoptee up to 21 years of age if the department determines that the child has a mental or physical disability that warrants continuation of adoption assistance and the child was adopted before 16 years of age.

(4) If sufficient funds are appropriated by the legislature in the department's annual budget, redetermined adoption assistance agreements may be extended through state funding for an eligible adoptee up to 21 years of age if the department determines that the child has a mental or physical disability that warrants continuation of adoption assistance and the child was adopted before 16 years of age.

(5) Adoption assistance agreements or redetermined adoption assistance agreements may be extended for a child adopted on or after his or her sixteenth birthday if the department determines that the eligible adoptee meets the requirements set forth in the young adult voluntary foster care act, 2011 PA 225, MCL 400.641 to 400.671.

(6) Adoption assistance, redetermined adoption assistance, and a medical subsidy shall continue even if the adoptive parent or the adoptee leaves the state.

(7) Support subsidy or redetermined adoption assistance shall continue during a period in which the adoptee is removed for delinquency from his or her home as a temporary court ward based on proceedings under section 18 of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.18.

(8) Upon the death of the adoptive parent, the department shall continue making support subsidy, redetermined adoption assistance payments, or continue medical subsidy eligibility, through state funding to the guardian of the adoptee if a guardian is appointed as provided in section 5202 or 5204 of the estates and protected individuals code, 1998 PA 386, MCL 700.5202 and 700.5204.

History: Add. 1994, Act 238, Eff. July 5, 1994;—Am. 2000, Act 61, Eff. Apr. 1, 2000;—Am. 2002, Act 648, Imd. Eff. Dec. 23, 2002 ;—Am. 2009, Act 17, Imd. Eff. Apr. 9, 2009;—Am. 2011, Act 230, Imd. Eff. Nov. 22, 2011;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Popular name: Act 280

400.115k Appeal of determination; notice of rights of appeal.

Sec. 115k. (1) An adoptee, the adoptee's guardian, or the adoptive parent or parents may appeal a determination of the department made under this act. The appeal shall be conducted pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. An appeal brought pursuant to chapter 6 of Act No. 306 of the Public Acts of 1969, being sections 24.301 to 24.306 of the Michigan Compiled Laws, shall be heard as follows:

(a) In the case of an adoptee residing in this state, by the probate court for the county in which the petition

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for adoption was filed or the county in which the adoptee is found.

(b) In the case of an adoptee not residing in this state, by the probate court for the county in which the petition for adoption was filed.

(2) The department shall notify the adoptee and the adoptive parent or parents of their rights of appeal under this section.

History: Add. 1994, Act 238, Eff. July 5, 1994.

Popular name: Act 280

400.115*l* Child with special needs; agreement for payment of nonrecurring adoption expenses; limitation; signature; filing claims; notice to potential claimants.

Sec. 115*l*. (1) The department shall enter into an agreement with the adoptive parent of a child with special needs under this section for the payment of nonrecurring adoption expenses incurred by or on behalf of the adoptive parent. The agreement may be a separate document or part of an adoption assistance agreement under section 115i. The agreement under this section shall indicate the nature and amount of nonrecurring adoption expenses to be paid by the department, which shall not exceed $2,000.00 for each adoptive placement meeting the requirements of this section. The department shall make payment as provided in the agreement.

(2) An agreement under this section shall be signed at or before entry of an order of adoption under the adoption code. Claims for payment shall be filed with the department within 2 years after entry of the order of adoption.

(3) The department shall take all actions necessary and appropriate to notify potential claimants under this section, including compliance with federal regulations.

History: Add. 1994, Act 238, Eff. July 5, 1994;—Am. 2002, Act 648, Imd. Eff. Dec. 23, 2002;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Popular name: Act 280

400.115m Information describing adoption process and adoption assistance and medical subsidy programs; preparation; distribution; contents.

Sec. 115m. (1) The department shall prepare and distribute to adoption facilitators and other interested persons information describing the adoption process and the adoption assistance and medical subsidy programs established under sections 115f to 115s. The state department shall provide the information to each prospective adoptive parent before placing a child with that parent.

(2) The description of the adoption process required under subsection (1) shall include at least all of the following:

(a) The steps that must be taken under the adoption code to complete an adoption, and a description of all of the options available during the process.

(b) A description of the services that are typically available from each type of adoption facilitator.

(c) Recommended questions for a biological parent or prospective adoptive parent to ask an adoption facilitator before engaging that adoption facilitator's services.

(d) A list of the rights and responsibilities of biological parents and prospective adoptive parents.

(e) A description of the information services available to biological and prospective adoptive parents including, but not limited to, all of the following:

(*i*) The registry of adoptive homes established and maintained by the department under section 8 of the foster care and adoption services act, 1994 PA 203, MCL 722.958.

(*ii*) The directory of children that is produced under section 8 of the foster care and adoption services act, 1994 PA 203, MCL 722.958.

(*iii*) The public information forms maintained by the department according to section 14d of 1973 PA 116, MCL 722.124d.

(f) A statement about the existence of the children's ombudsman and its authority as an investigative body.

(g) A statement about the importance and availability of counseling for all parties to an adoption and that a prospective adoptive parent must pay for counseling for a birth parent or guardian unless the birth parent or guardian waives the counseling.

History: Add. 1994, Act 207, Eff. Jan. 1, 1995;—Am. 2002, Act 648, Imd. Eff. Dec. 23, 2002;—Am. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Popular name: Act 280

400.115n Escape of juvenile from facility or residence; notification; definitions.

Sec. 115n. (1) If a juvenile escapes from a facility or residence funded or authorized under this act in

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which he or she has been placed, other than his or her own home or the home of his or her parent or guardian, the individual at that facility or residence having responsibility for maintaining custody of the juvenile at the time of the escape shall immediately notify 1 of the following of the escape or cause 1 of the following to be immediately notified of the escape:

(a) If the escape occurs in a city, village, or township that has a police department, the police department of that city, village, or township.

(b) Except as provided in subdivision (a), 1 of the following:

(*i*) The sheriff department of the county in which the escape occurs.

(*ii*) The department of state police post having jurisdiction over the area in which the escape occurs.

(2) A police agency that receives notification of an escape under subsection (1) shall enter that notification into the law enforcement information network without undue delay.

(3) As used in this section:

(a) "Escape" means to leave without lawful authority or to fail to return to custody when required.

(b) "Juvenile" means 1 or more of the following:

(*i*) An individual under the jurisdiction of the juvenile division of the probate court or the family division of circuit court under section 2(a)(1) of chapter XIIA of Act No. 288 of the Public Acts of 1939, being section 712A.2 of the Michigan Compiled Laws.

(*ii*) An individual under the jurisdiction of the circuit court under section 606 of the revised judicature act of 1961, Act No. 236 of the Public Acts of 1961, being section 600.606 of the Michigan Compiled Laws.

(*iii*) An individual under the jurisdiction of the recorder's court of the city of Detroit under section 10a(1)(c) of Act No. 369 of the Public Acts of 1919, being section 725.10a of the Michigan Compiled Laws.

History: Add. 1996, Act 483, Eff. Jan. 1, 1997.

Popular name: Act 280

400.115o Residential care bed space for juveniles; "appropriate juvenile residential care provider" defined.

Sec. 115o. (1) Both of the following apply to residential care bed space for juveniles who are within or likely to come within the court's jurisdiction under section 2(a) or (d) of chapter XIIA of 1939 PA 288, MCL 712A.2, or committed to the department under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309:

(a) If 1 or more appropriate juvenile residential care providers located or doing business in this state have bed space available, the department shall use that space rather than a space available by a provider located or doing business in another state. This requirement does not apply if the provider located or doing business in another state offers a specialized program that is not available in this state.

(b) If an excess of bed spaces is available within a security level, the department shall use the bed spaces of private providers with whom it has contracted and allow state owned bed spaces to go unused first. However, in applying this subdivision, a bed space that is available because a facility refused to accept a juvenile does not count toward a surplus.

(2) As used in this section, "appropriate juvenile residential care provider" means a private nonprofit entity domiciled in this state that is licensed by the department of consumer and industry services and that entered into 1 or more contracts with the family independence agency to provide residential care services for juveniles on or before the effective date of the amendatory act that added this section.

History: Add. 1998, Act 516, Imd. Eff. Jan. 12, 1999.

Popular name: Act 280

400.115p Local elected official or employee as advisor to juvenile facility; "elected official" and "juvenile facility" defined.

Sec. 115p. (1) An appointed board, commission, or similar entity that acts in an advisory capacity to a juvenile facility shall have at least 1 member who is an elected official or administrative employee of the city, village, or township in which the juvenile facility is located.

(2) As used in this section:

(a) "Elected official" means the elected chief executive officer of the city, village, or township or a member of the legislative body of the city, village, or township.

(b) "Juvenile facility" means a facility operated or administered by the state that houses juveniles who are within or likely to come within the court's jurisdiction under section 2 of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2.

History: Add. 1999, Act 169, Imd. Eff. Nov. 8, 1999.

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Popular name: Act 280

400.115q Field investigation or home visit; training program; documentation of safety risk; completion with another department employee or law enforcement officer.

Sec. 115q. (1) The department shall develop, implement, and provide a training program to each department employee who is required to perform a field investigation or home visit. The training program shall include both of the following:

(a) Mandatory training on defusing threatening behavior.

(b) Mandatory training on how to perform a safe investigation or home visit and recognize a potentially dangerous situation.

(2) If a department employee who is required to perform a field investigation or home visit has documented a risk that leads to a reasonable apprehension regarding the safety of performing a field investigation or home visit, that employee shall complete the field investigation or home visit with another department employee who has been trained as required in subsection (1) or with a law enforcement officer.

History: Add. 2001, Act 14, Eff. Sept. 1, 2001.

Popular name: Act 280

400.115r Interstate compact on adoption and medical assistance; citation of MCL 400.115r and 400.115s.

Sec. 115r. (1) Sections 115r and 115s shall be known and may be cited as the "interstate compact on adoption and medical assistance".

(2) By the enactment of sections 115r and 115s, this state becomes a party state.

(3) Sections 115r and 115s shall be liberally construed to accomplish all of the following:

(a) Strengthen protections for each adoptee who is a child with special needs on behalf of whom a party state commits to pay adoption assistance when that child's residence state is a state other than the state committed to provide the adoption assistance.

(b) Provide substantive assurances and operating procedures that promote the delivery of medical assistance and other services to a child on an interstate basis through medical assistance programs established by the laws of each state that is a party to the compact.

History: Add. 2002, Act 648, Imd. Eff. Dec. 23, 2002.

Popular name: Act 280

400.115s Interstate compacts; authorization; force and effect; contents.

Sec. 115s. (1) The family independence agency is authorized to negotiate and enter into interstate compacts with agencies of other states for the provision of adoption assistance for an adoptee who is a child with special needs, who moves into or out of this state, and on behalf of whom adoption assistance is being provided by this state or another state party to such a compact.

(2) When a compact is so entered into and for as long as it remains in force, the compact has the force and effect of law.

(3) A compact authorized under this act must include:

(a) A provision making it available for joinder by all states.

(b) A provision or provisions for withdrawal from the compact upon written notice to the parties, but with a period of 1 year between the date of the notice and effective date of the withdrawal.

(c) A requirement that the protections under the compact continue in force for the duration of the adoption assistance and are applicable to all children and their adoptive parents who on the effective date of the withdrawal are receiving adoption assistance from a party state other than the one in which they are resident and have their principal place of abode.

(d) A requirement that each instance of adoption assistance to which the compact applies be covered by an adoption assistance agreement in writing between the adoptive parents and the state child welfare agency of the state that undertakes to provide the adoption assistance. An agreement required by this subdivision shall be expressly for the benefit of the adopted child and be enforceable by the adoptive parents and the state agency providing the adoption assistance.

(e) Other provisions as may be appropriate to implement the proper administration of the compact.

History: Add. 2002, Act 648, Imd. Eff. Dec. 23, 2002.

Popular name: Act 280

400.115t Redetermined adoption assistance; request; requirements; hearing; effect of original agreement; determination; basis; adoption assistance agreement in place before

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January 1, 2015; limitation on number of requests; adoptee adopted from foster care between ages of 0 and 18 and finalized after January 1, 2015.

Sec. 115t. (1) If sufficient funds are appropriated in the department's annual budget and subject to subsection (4), beginning January 1, 2015, the department shall pay redetermined adoption assistance to an adoptive parent of an adoptee who is placed in the adoptive parent's home under the adoption code or under the adoption laws of another state or a tribal government, if the adoptive parent requests redetermined adoption assistance and both of the following requirements are met:

(a) The department has certified that the adoptee requires extraordinary care or expense due to a condition the cause of which existed before the adoption was finalized.

(b) Certification is made before the adoptee's eighteenth birthday.

(2) If the department denies or the adoptive parent disagrees with the certification, the adoptive parent may request a hearing through an administrative law judge in a manner consistent with the rules promulgated under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(3) Redetermined adoption assistance does not affect or duplicate any original adoption assistance agreement that may be in place at the time that redetermined adoption assistance eligibility is requested. Redetermined adoption assistance shall be determined without regard to the income of the adoptive parent and shall be based on 1 or more of the following for which extraordinary care is required of the adoptive parent or an extraordinary expense exists in excess of a support subsidy:

(a) A physically disabled child for whom the adoptive parent must provide measurably greater supervision and care.

(b) A child with special psychological or psychiatric needs that require extra time and a measurably greater amount of care and attention by the adoptive parent.

(c) A child requiring a special diet that is more expensive than a normal diet and that requires extra time and effort by the adoptive parent to obtain and prepare.

(d) A child whose severe acting out or antisocial behavior requires a measurably greater amount of care and attention of the adoptive parent.

(e) Any other condition for which the department determines that extraordinary care is required of the adoptive parent or an extraordinary expense exists.

(4) An adoptive parent who has an adoption assistance agreement signed and in effect before January 1, 2015 may request redetermined adoption assistance under this section in the same manner as provided in this section beginning January 1, 2015 but not after March 31, 2015.

(5) An adoptive parent may only request 1 redetermined adoption assistance certification to be made under subsection (1) or (4) per adoptee placed in the adoptive parent's home.

(6) An adoptive parent of an adoptee who was adopted from foster care between the ages of 0 and 18 and whose adoption was finalized after January 1, 2015 may request redetermined adoption assistance under this section.

History: Add. 2014, Act 308, Imd. Eff. Oct. 10, 2014.

Popular name: Act 280

400.116 Duties of department with respect to juvenile court probation staff; consultation and assistance services; plan for voluntary transfer of county juvenile court probation staff to department.

Sec. 116. (1) With respect to juvenile court probation staff in a county that is not a county juvenile agency, the department shall do all of the following:

(a) Develop and recommend to the supreme court standards and qualifications for employment and other criteria designed to develop an adequate career service.

(b) Maintain information as to court employment needs and assist in recruiting qualified personnel.

(c) Provide, with legislative approval, a statewide system of preservice and inservice training, which may include full or part-time scholarships.

(d) Develop recommendations regarding the functions of the office of county juvenile officer.

(2) The department may provide consultation and assistance services to the juvenile probation service of the court in a county that is not a county juvenile agency.

(3) The department shall develop a plan that permits the voluntary transfer of county juvenile court probation staff in a county that is not a county juvenile agency to the department by the joint concurrence of the county board of commissioners or county executive, as applicable, and the chief judge of the family division of circuit court. The plan shall include procedures for negotiations between the state, as represented by the department, and the affected county board of commissioners or county executive, the county family

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independence agency board, and the chief judge of the family division of circuit court for that county. The plan shall afford juvenile court probation staff transferred under the plan the opportunity to be employed in the state classified civil service in compliance with procedures established by the Michigan civil service commission. The plan shall enable the court to maintain sufficient staff to enforce court orders and to perform the preliminary inquiry and monitoring of court wards required by chapter XIIA of 1939 PA 288, MCL 712A.1 to 712A.32. The plan shall be submitted to the legislature not later than 18 months after the effective date of this subsection.

(4) As used in this section, "county juvenile agency" means that term as defined in section 2 of the county juvenile agency act.

History: Add. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1972, Act 301, Eff. Jan. 1, 1973;—Am. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1998, Act 516, Imd. Eff. Jan. 12, 1999.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.117 Repealed. 1972, Act 301, Eff. Jan. 1, 1973.

Compiler's note: The repealed section pertained to avoiding the loss of federal matching funds.

Popular name: Act 280

***** *400.117a THIS SECTION IS AMENDED EFFECTIVE MARCH 28, 2019: See 400.117a.amended* *****

400.117a Definitions; juvenile justice funding system; rules; distribution of money for cost of juvenile justice services; reimbursement for costs; limitation; request for payment; offset, chargeback, or reimbursement liability; guidelines; reports; reporting system.

Sec. 117a. (1) As used in this section and sections 117b to 117h:

(a) "County juvenile agency" means that term as defined in section 2 of the county juvenile agency act, 1998 PA 518, MCL 45.622.

(b) "County juvenile agency services" means all juvenile justice services for a juvenile who is within the court's jurisdiction under section 2(a) or (d) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, or within the jurisdiction of the court of general jurisdiction under section 606 of the revised judicature act of 1961, 1961 PA 236, MCL 600.606, if that court commits the juvenile to a county or court juvenile facility under section 27a of chapter IV of the code of criminal procedure, 1927 PA 175, MCL 764.27a. If a juvenile who comes within the court's jurisdiction under section 2(a) or (d) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, is at that time subject to a court order in connection with a proceeding for which the court acquired jurisdiction under section 2(b) or (c) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, juvenile justice services provided to the juvenile before the court enters an order in the subsequent proceeding are not county juvenile agency services, except for juvenile justice services related to detention.

(c) "Donated funds" means any gifts of money made available to the county child care fund for services for child welfare or delinquency matters, including juvenile justice services.

(d) "Donor" means the entity, person, or persons providing the donated funds.

(e) "Gross expenditure" means the total adjusted expenditures included in a county's monthly expenditure report and submitted to the department.

(f) "In-home care" means expenditure of child care fund money for services and items listed in this section to be an alternative to out-of-home care or to provide an early return home for a child placed out of his or her home.

(g) "Juvenile detention facility" means a county-operated or court-operated juvenile facility that houses and provides group care, shelter care, or detention administered and staffed by county or court employees.

(h) "Juvenile justice service" means a service, exclusive of judicial functions, provided by a county for juveniles who are within or likely to come within the court's jurisdiction under section 2 of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, or within the jurisdiction of the court of general criminal jurisdiction under section 606 of the revised judicature act of 1961, 1961 PA 236, MCL 600.606, if that court commits the juvenile to a county or court juvenile facility under section 27a of chapter IV of the code of criminal procedure, 1927 PA 175, MCL 764.27a. A service includes intake, detention, detention alternatives, probation, foster care, diagnostic evaluation and treatment, shelter care, or any other service approved by the office or county juvenile agency, as applicable, including preventive, diversionary, or

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protective care services. A juvenile justice service approved by the office or county juvenile agency must meet all applicable state and local government licensing standards.

(i) "Out-of-home care" means placement outside of the residence of the child's parent, legal guardian, or, except as provided in this subdivision, relative where the child is found, from which the child was removed by the authority of the court, or in which the child will be placed on a permanent basis.

(j) "Technology and software" means risk and needs assessment software or software directly related to treatment or services provided within a reimbursable in-home care program. Technology and software does not include the purchase of new equipment or hardware, or maintenance of equipment or hardware for the reimbursable in-home care program. Technology and software also does not include new equipment cost, maintenance of equipment, technology, or software used exclusively for general support for the court.

(2) A juvenile justice funding system for counties that are not county juvenile agencies, including a child care fund, is established and shall be administered under the department's superintending control.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to monitor juvenile justice services money and to prescribe child care fund accounting, reporting, and authorization controls and procedures and child care fund expenditure classifications. For counties required to have a child care fund, the department shall fund services that conform to the child care rules promulgated under this act.

(4) The department shall distribute money appropriated by the legislature to counties for the cost of juvenile justice services as follows:

(a) Payment for expenditures for children placed with the department for care, supervision, or placement, including children who are within the court's jurisdiction under section 2(a) and (b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, shall be paid by the department and reimbursed by the county for all undisputed charges. Implementation of this subdivision takes effect on October 1 of the fiscal year following the appropriation to support new payment processes and the implementation of technological changes to the statewide automated child welfare information system.

(b) Payment for expenditures for children not placed with the department for care, supervision, or placement, including children who are within the court's jurisdiction under section 2(a) and (b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, shall be paid by a county and be reimbursed by the department for all undisputed charges. Expenditures described in this subdivision include the following:

(*i*) Direct expenditures for out-of-home care, including all of the following:

(A) Salaries of county- or court-operated detention center, shelter care, or group care facility specific employees, including, but not limited to, all of the following:

(I) Management staff of a facility.

(II) Direct service staff of a facility.

(III) Mental health staff of a facility.

(IV) Support staff including clerical staff of a facility.

(V) Janitorial, maintenance, or ground staff of a facility, or any combination of these.

(VI) Kitchen staff of a facility.

(VII) Security staff of a facility.

(VIII) Circuit court employees who support the child care fund county- or court-operated detention center, shelter care, or group care facility.

(B) Fringe benefits, including payroll taxes, medical, vision and dental insurance, group life insurance, disability insurance, accident insurance, health savings accounts, retirement contributions, worker's compensation, and accrued severance benefits of county- or court-operated detention center, shelter care, or group care facility specific employees and circuit court administration who administrate and support the child care fund county- or court-operated detention center, shelter care, or group care facility.

(C) Clothing for children.

(D) Food for children.

(E) Meals furnished to staff who are on duty at a county- or court-operated detention center, shelter care, or group care facility and assigned responsibilities for the supervision and care of the youth during facility mealtime.

(F) Hygiene supplies for children, including shampoo, soap, or toothpaste.

(G) Education costs for children who are temporary residents in a county- or court-operated detention center, shelter care, or group care facility and for whom attendance in a public school system or local education agency is not an option.

(H) Utilities of a county- or court-operated detention center, shelter care, or group care facility, including water, gas, electric, trash, and sewer.

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(I) Janitorial supplies of a county- or court-operated detention center, shelter care, or group care facility.

(J) Kitchen supplies of a county- or court-operated detention center, shelter care, or group care facility.

(K) Laundry supplies or service of a county- or court-operated detention center, shelter care, or group care facility.

(L) Linen supplies or service of a county- or court-operated detention center, shelter care, or group care facility, including towels and bedding.

(M) Office supplies that are dedicated solely to the county- or court-operated detention center, shelter care, or group care facility.

(N) Cellular telephones, landline telephones, and 2-way radios used for communication that are dedicated solely to the county- or court-operated detention center, shelter care, or group care facility.

(O) Copy machine charges that are dedicated to the county- or court-operated detention center, shelter care, or group care facility.

(P) Mattress, box spring, or bed frame used in a county- or court-operated detention center, shelter care, or group care facility.

(Q) Medical, dental, psychological, and psychiatric services, including medication, for children who are not covered by another source which services are not to determine competency.

(R) Periodicals and books of a county- or court-operated detention center, shelter care, or group care facility.

(S) Recreational supplies, programs, and television in a county- or court-operated detention center, shelter care, or group care facility.

(T) Training for child care fund-funded staff and in-service education directly related to the out-of-home program, excluding tuition grants or scholarships for college credit.

(U) Mileage reimbursement rate costs for transporting children of a county- or court-operated detention center, shelter care, or group care facility. Mileage reimbursement rates used must adhere to the county or tribe published rates. Mileage reimbursement rates cover all costs of operating a vehicle, including maintenance, repairs, taxes, gas, insurance, and registration fees.

(V) Drug testing for children.

(W) Birth certificates for children.

(X) Incentives for youth.

(Y) Interpreter fees for nonjudicial processes.

(Z) Printing, binding, and postage for materials relating to the education or correspondence relating to children in the county- or court-operated detention center, shelter care, or group care facility.

(AA) Membership dues or fees for professional credential maintenance of staff who provide or support a service to children under the child care fund, or professional staff for whom professional licensure is required in their respective job description.

(BB) Contracted personnel, programming, or services, or any combination of these.

(CC) Nonscheduled payments.

(DD) New services that the department may agree with counties and tribes to include that are not identified in this section that support eligible children and families.

(*ii*) Administrative or indirect expenditures for out-of-home care. An administrative or indirect cost payment equal to 10% of a county's total monthly gross expenditures will automatically be distributed to the county on a monthly basis. A county is not required to submit documentation to the department for any of the expenditures that are covered under the 10% payment.

(*iii*) Direct expenditures for in-home care, including the following:

(A) Salaries of circuit court employees who support the child care fund in-home care program.

(B) Fringe benefits, including payroll taxes, medical and dental insurance, group life insurance, disability insurance, accident insurance, health savings accounts, retirement contributions, and accrued severance benefits of circuit court employees who support the child care fund in-home care program. For a county that receives the juvenile court officer grant and the appointed juvenile court officer works within an approved program, the proportional fringe benefits for the juvenile court officer may be reimbursable.

(C) Mileage reimbursement rate costs associated with the child care fund in-home care program. Mileage reimbursement rates used must adhere to the county or tribe published rates. Mileage reimbursement rates cover all costs of operating a vehicle, including maintenance, repairs, taxes, gas, insurance, and registration fees.

(D) Program supplies and materials, including, but not limited to, all of the following:

(I) Program-specific supplies, including risk or needs assessments, recognition plaques, and educational or program licenses.

(II) Office supplies related to program activities and pro-social activities.

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(III) Food related to program activities and pro-social activities.

(IV) Drug test kits.

(V) Tethers and other forms of electronic monitoring.

(E) Other costs, including all of the following:

(I) Cellular telephones and other safety tracking technology for child care fund-funded staff.

(II) Training for child care fund-funded staff and in-service education related to the in-home care component, excluding tuition grants or scholarships for college credit.

(III) Education costs for children who are prohibited from school attendance in a public school system or the local education agency or have severe educational issues and have been court ordered into a child care fund-funded educational program.

(IV) Printing, binding, or postage for materials relating to the education or correspondence on behalf of children in the in-home care program.

(V) Membership dues or fees – professional credential maintenance of staff who provide or support a service to children under the child care fund or professional staff for whom professional licensure is required in their respective job descriptions.

(VI) Business cards.

(F) Other program-specific activities costs, including entrance fees for programs.

(G) Conference travel costs for other non-child-care-fund-related training, including evidence-based and promising practices training.

(H) Contracted personnel, programming, or services, or any combination of these.

(I) Unit cost contracts, including all of the following:

(I) Contracted - drug testing – lab (per "drug test" basis).

(II) Contracted - counselor fees – (per "hour" basis).

(III) Contracted - group session dollar per session (per "session" basis). Group roster documentation required.

(IV) Contracted - psychological evaluations, excluding competency examinations – (per "evaluation" basis).

(V) Contracted - service providers (per "service" basis).

(J) Closed-end contracts. Closed-end contracts include, but are not limited to, all of the following:

(I) University contracts, including "program evaluation".

(II) Private agency services contracts.

(III) Educational services contracts.

(IV) Court appointed special advocate (CASA) and wraparound contracts.

(V) Other contracts identifiable to the program.

(K) Nonscheduled payments or case services payments. A nonscheduled payment is a payment to an individual or organization for items specified and defined in the child care fund handbook that are not included in the state-established per diem rate. A nonscheduled payment may include the following list:

(I) Emergency costs, including immediate food, clothing, medical, or dental needs that are not covered by another source.

(II) Gymnasium or other pro-social activity requiring a membership per child related to program activities.

(III) Rewards or incentive pay for youth related to program activities.

(IV) Bus tokens or gas cards related to program activities.

(V) Mentor costs - meals, mileage, movies, or social costs related to program activities.

(VI) Noncontracted service provider related to program activities.

(VII) Noncontracted group session related to program activities.

(VIII) Noncontracted psychological evaluations, excluding competency examinations.

(IX) Family assessment or evaluations.

(X) Noncontracted counselor fees.

(XI) Noncontracted drug testing – labs.

(XII) Camps or field trips.

(XIII) Birth certificates for children.

(L) New services that the department may agree with counties and tribes to include that are not identified in this section that support eligible children and families.

(M) Technology and software.

(*iv*) Administrative or indirect expenditures for in-home care. An administrative or indirect cost payment equal to 10% of a county's total monthly gross expenditures will automatically be distributed to the county on a monthly basis. A county is not required to submit documentation to the department for any of the expenditures that are covered under the 10% payment.

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(c) The county amount distributed shall equal 50% of the annual expenditures from the child care fund of the county established under section 117c, except that expenditures under section 117c(3) and expenditures that exceed the amount of a budget approved under section 117c shall not be included. A distribution under this subdivision shall not be made to a county that does not comply with the requirements of this act. Subject to a county's approval, the department may reduce the amount distributed to a county by the amount owed to the state for care received in a state operated facility or for care received under 1935 PA 220, MCL 400.201 to 400.214, or under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309.

(d) For a county that is a county juvenile agency, a county's block grant amount as determined under section 117g in equal distributions on October 1, January 1, April 1, and July 1 of each state fiscal year.

(e) Notwithstanding the provisions in subdivision (a), subject to appropriations, the department shall pay 100% of the costs of the $9.20 increase to the administrative rate for providers of foster care services provided in the annual appropriation for the department budget. For the purposes of this subdivision only, "foster care" means 24-hour substitute care for children placed away from their parents or guardians, as a result of a court order under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, in placements supervised by the department or a private child placing agency under contract with the department for foster care services. Foster care services include supervision of placements in foster family homes, foster family group homes, and preadoptive placements.

(f) Notwithstanding the provisions of subdivision (c), the department shall pay 100% of the administrative rate that is in effect on the effective date of the 2018 amendatory act that amended this subdivision for providers of treatment foster care services and foster care services provided in the annual appropriation for the department budget. For the purposes of this subdivision only, "foster care" means 24-hour substitute care for children placed away from their parents or guardians, as a result of a court order under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, in placements supervised by the department or a private child placing agency under contract with the department for foster care services. Foster care services include supervision of placements in foster family homes, foster family group homes, treatment foster care, preadoptive placements, and supervision of children reunified with the parent with whom the child lived at the time of removal.

(g) Notwithstanding the provisions in subdivision (c), the department shall pay 100% of the costs of any rate increase that is in effect on the effective date of the 2018 amendatory act that amended this subdivision to the providers of residential foster care services under contract with the department, as provided in the annual appropriation for the department budget.

(h) Notwithstanding the provisions in subdivision (c) and subject to appropriations, in a county with a population of not less than 575,000 or more than 650,000, for the purpose of this subdivision only for cases transferred by the department to a child placing agency, the department shall pay 100% of the administrative rate to providers responsible for foster care case management services to families of children who are court-ordered into foster care due to child abuse or child neglect and placed in the care and supervision of the department, regardless of placement setting until the prospective payment system described in subdivision (i) is implemented. This subdivision does not apply after May 1, 2019.

(i) Notwithstanding the provisions in subdivision (c) and subject to appropriations, the department shall implement a prospective payment system as part of a state-administered performance-based child welfare system in a county with a population of not less than 575,000 or more than 650,000, for foster care case management in accordance with section 503 of article X of 2014 PA 252. The county is only required to contribute to foster care services payments in an amount that does not exceed the average of the annual net contribution made by the county for cases received under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, in the 5 previous fiscal years before October 1, 2015. The prospective payment system as part of the state-administered performance-based child welfare system shall be implemented as described in this subdivision but shall not include in-home care service funding. This subdivision does not apply after May 1, 2019.

(j) Subdivisions (h) and (i) only impact child abuse and child neglect services and not juvenile justice program funding. This subdivision does not apply after May 1, 2019.

(5) The purposes for which funding under this section shall be distributed as provided under subsection (4) may be allowed unless otherwise accessible and available by other public assistance programs necessary to achieve the goals and outcomes for in-home care or out-of-home care. Reimbursement shall not be made for costs associated with an otherwise eligible child or family, or both, if the reason for the unavailability of public assistance is due to intentional program violations and disqualification of any public assistance.

(6) All service providers shall submit a request for payment within 1 calendar year of the date of service. A request for payment submitted after 1 calendar year from the date of service requires the provider to submit an exception request to the county or the department for approval or denial.

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(7) The county or the department is not subject to an offset, chargeback, or reimbursement liability when a child care fund cost is approved by the county or the department for payment after 1 year from the date of service.

(8) The county is not subject to an offset, chargeback, or reimbursement liability for prior expenditures resulting from an error in foster care fund source determinations.

(9) The department is liable for the costs of all juvenile justice services in a county that is a county juvenile agency other than county juvenile agency services.

(10) The department shall establish guidelines for the development of county juvenile justice service plans in counties that are not county juvenile agencies.

(11) A county that is not a county juvenile agency and receives state funds for in-home or out-of-home care of children shall submit reports to the department at least quarterly or as the department otherwise requires. The reports shall be submitted on forms provided by the executive director and shall include the number of children receiving foster care services and the number of days of care provided.

(12) The department shall maintain a reporting system providing that reimbursement under subsection (4)(c) shall be made only on submission of billings based on care given to a specific, individual child.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1980, Act 328, Imd. Eff. Dec. 19, 1980;—Am. 1988, Act 75, Eff. Oct. 1, 1988;—Am. 1998, Act 516, Imd. Eff. Jan. 12, 1999;—Am. 2013, Act 138, Imd. Eff. Oct. 15, 2013;—Am. 2014, Act 304, Imd. Eff. Oct. 9, 2014;—Am. 2014, Act 520, Imd. Eff. Jan. 14, 2015;—Am. 2015, Act 81, Eff. Oct. 1, 2015;—Am. 2016, Act 279, Eff. Oct. 1, 2016;—Am. 2017, Act 104, Eff. Oct. 11, 2017;—Am. 2018, Act 22, Eff. May 15, 2018;—Am. 2018, Act 244, Eff. Sept. 26, 2018.

Compiler's note: Section 3 of Act 75 of 1988 provides: "This amendatory act shall take effect June 1, 1988." This section was amended by Act 178 of 1988 to read as follows: "This amendatory act shall take effect October 1, 1988."

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

***** *400.117a.amended THIS AMENDED SECTION IS EFFECTIVE MARCH 28, 2019* *****

400.117a.amended Definitions; juvenile justice funding system; rules; distribution of money for cost of juvenile justice services; reimbursement for costs; limitation; request for payment; offset, chargeback, or reimbursement liability; guidelines; reports; reporting system.

Sec. 117a. (1) As used in this section and sections 117b to 117h:

(a) "County juvenile agency" means that term as defined in section 2 of the county juvenile agency act, 1998 PA 518, MCL 45.622.

(b) "County juvenile agency services" means all juvenile justice services for a juvenile who is within the court's jurisdiction under section 2(a) or (d) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, or within the jurisdiction of the court of general jurisdiction under section 606 of the revised judicature act of 1961, 1961 PA 236, MCL 600.606, if that court commits the juvenile to a county or court juvenile facility under section 27a of chapter IV of the code of criminal procedure, 1927 PA 175, MCL 764.27a. If a juvenile who comes within the court's jurisdiction under section 2(a) or (d) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, is at that time subject to a court order in connection with a proceeding for which the court acquired jurisdiction under section 2(b) or (c) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, juvenile justice services provided to the juvenile before the court enters an order in the subsequent proceeding are not county juvenile agency services, except for juvenile justice services related to detention.

(c) "Donated funds" means any gifts of money made available to the county child care fund for services for child welfare or delinquency matters, including juvenile justice services.

(d) "Donor" means the entity, person, or persons providing the donated funds.

(e) "Gross expenditure" means the total adjusted expenditures included in a county's monthly expenditure report and submitted to the department.

(f) "In-home care" means expenditure of child care fund money for services and items listed in this section to be an alternative to out-of-home care or to provide an early return home for a child placed out of his or her home.

(g) "Juvenile detention facility" means a county-operated or court-operated juvenile facility that houses and provides group care, shelter care, or detention administered and staffed by county or court employees.

(h) "Juvenile justice service" means a service, exclusive of judicial functions, provided by a county for juveniles who are within or likely to come within the court's jurisdiction under section 2 of chapter XIIA of

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the probate code of 1939, 1939 PA 288, MCL 712A.2, or within the jurisdiction of the court of general criminal jurisdiction under section 606 of the revised judicature act of 1961, 1961 PA 236, MCL 600.606, if that court commits the juvenile to a county or court juvenile facility under section 27a of chapter IV of the code of criminal procedure, 1927 PA 175, MCL 764.27a. A service includes intake, detention, detention alternatives, probation, foster care, diagnostic evaluation and treatment, shelter care, or any other service approved by the office or county juvenile agency, as applicable, including preventive, diversionary, or protective care services. A juvenile justice service approved by the office or county juvenile agency must meet all applicable state and local government licensing standards.

(i) "Out-of-home care" means placement outside of the residence of the child's parent, legal guardian, or, except as provided in this subdivision, relative where the child is found, from which the child was removed by the authority of the court, or in which the child will be placed on a permanent basis.

(j) "Technology and software" means risk and needs assessment software or software directly related to treatment or services provided within a reimbursable in-home care program. Technology and software does not include the purchase of new equipment or hardware, or maintenance of equipment or hardware for the reimbursable in-home care program. Technology and software also does not include new equipment cost, maintenance of equipment, technology, or software used exclusively for general support for the court.

(2) A juvenile justice funding system for counties that are not county juvenile agencies, including a child care fund, is established and shall be administered under the department's superintending control.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to monitor juvenile justice services money and to prescribe child care fund accounting, reporting, and authorization controls and procedures and child care fund expenditure classifications. For counties required to have a child care fund, the department shall fund services that conform to the child care rules promulgated under this act.

(4) The department shall distribute money appropriated by the legislature to counties for the cost of juvenile justice services as follows:

(a) Payment for expenditures for children placed with the department for care, supervision, or placement, including children who are within the court's jurisdiction under section 2(a) and (b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, shall be paid by the department and reimbursed by the county for all undisputed charges. Implementation of this subdivision takes effect on October 1 of the fiscal year following the appropriation to support new payment processes and the implementation of technological changes to the statewide automated child welfare information system.

(b) Payment for expenditures for children not placed with the department for care, supervision, or placement, including children who are within the court's jurisdiction under section 2(a) and (b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, shall be paid by a county and be reimbursed by the department for all undisputed charges. Expenditures described in this subdivision include the following:

(*i*) Direct expenditures for out-of-home care, including all of the following:

(A) Salaries of county- or court-operated detention center, shelter care, or group care facility specific employees, including, but not limited to, all of the following:

(I) Management staff of a facility.

(II) Direct service staff of a facility.

(III) Mental health staff of a facility.

(IV) Support staff including clerical staff of a facility.

(V) Janitorial, maintenance, or ground staff of a facility, or any combination of these.

(VI) Kitchen staff of a facility.

(VII) Security staff of a facility.

(VIII) Circuit court employees who support the child care fund county- or court-operated detention center, shelter care, or group care facility.

(B) Fringe benefits, including payroll taxes, medical, vision and dental insurance, group life insurance, disability insurance, accident insurance, health savings accounts, retirement contributions, worker's compensation, and accrued severance benefits of county- or court-operated detention center, shelter care, or group care facility specific employees and circuit court administration who administrate and support the child care fund county- or court-operated detention center, shelter care, or group care facility.

(C) Clothing for children.

(D) Food for children.

(E) Meals furnished to staff who are on duty at a county- or court-operated detention center, shelter care, or group care facility and assigned responsibilities for the supervision and care of the youth during facility mealtime.

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(F) Hygiene supplies for children, including shampoo, soap, or toothpaste.

(G) Education costs for children who are temporary residents in a county- or court-operated detention center, shelter care, or group care facility and for whom attendance in a public school system or local education agency is not an option.

(H) Utilities of a county- or court-operated detention center, shelter care, or group care facility, including water, gas, electric, trash, and sewer.

(I) Janitorial supplies of a county- or court-operated detention center, shelter care, or group care facility.

(J) Kitchen supplies of a county- or court-operated detention center, shelter care, or group care facility.

(K) Laundry supplies or service of a county- or court-operated detention center, shelter care, or group care facility.

(L) Linen supplies or service of a county- or court-operated detention center, shelter care, or group care facility, including towels and bedding.

(M) Office supplies that are dedicated solely to the county- or court-operated detention center, shelter care, or group care facility.

(N) Cellular telephones, landline telephones, and 2-way radios used for communication that are dedicated solely to the county- or court-operated detention center, shelter care, or group care facility.

(O) Copy machine charges that are dedicated to the county- or court-operated detention center, shelter care, or group care facility.

(P) Mattress, box spring, or bed frame used in a county- or court-operated detention center, shelter care, or group care facility.

(Q) Medical, dental, psychological, and psychiatric services, including medication, for children who are not covered by another source which services are not to determine competency.

(R) Periodicals and books of a county- or court-operated detention center, shelter care, or group care facility.

(S) Recreational supplies, programs, and television in a county- or court-operated detention center, shelter care, or group care facility.

(T) Training for child care fund-funded staff and in-service education directly related to the out-of-home program, excluding tuition grants or scholarships for college credit.

(U) Mileage reimbursement rate costs for transporting children of a county- or court-operated detention center, shelter care, or group care facility. Mileage reimbursement rates used must adhere to the county or tribe published rates. Mileage reimbursement rates cover all costs of operating a vehicle, including maintenance, repairs, taxes, gas, insurance, and registration fees.

(V) Drug testing for children.

(W) Birth certificates for children.

(X) Incentives for youth.

(Y) Interpreter fees for nonjudicial processes.

(Z) Printing, binding, and postage for materials relating to the education or correspondence relating to children in the county- or court-operated detention center, shelter care, or group care facility.

(AA) Membership dues or fees for professional credential maintenance of staff who provide or support a service to children under the child care fund, or professional staff for whom professional licensure is required in their respective job description.

(BB) Contracted personnel, programming, or services, or any combination of these.

(CC) Nonscheduled payments.

(DD) New services that the department may agree with counties and tribes to include that are not identified in this section that support eligible children and families.

(*ii*) Administrative or indirect expenditures for out-of-home care. An administrative or indirect cost payment equal to 10% of a county's total monthly gross expenditures will automatically be distributed to the county on a monthly basis. A county is not required to submit documentation to the department for any of the expenditures that are covered under the 10% payment.

(*iii*) Direct expenditures for in-home care, including the following:

(A) Salaries of circuit court employees who support the child care fund in-home care program.

(B) Fringe benefits, including payroll taxes, medical and dental insurance, group life insurance, disability insurance, accident insurance, health savings accounts, retirement contributions, and accrued severance benefits of circuit court employees who support the child care fund in-home care program. For a county that receives the juvenile court officer grant and the appointed juvenile court officer works within an approved program, the proportional fringe benefits for the juvenile court officer may be reimbursable.

(C) Mileage reimbursement rate costs associated with the child care fund in-home care program. Mileage reimbursement rates used must adhere to the county or tribe published rates. Mileage reimbursement rates

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cover all costs of operating a vehicle, including maintenance, repairs, taxes, gas, insurance, and registration fees.

(D) Program supplies and materials, including, but not limited to, all of the following:

(I) Program-specific supplies, including risk or needs assessments, recognition plaques, and educational or program licenses.

(II) Office supplies related to program activities and pro-social activities.

(III) Food related to program activities and pro-social activities.

(IV) Drug test kits.

(V) Tethers and other forms of electronic monitoring.

(E) Other costs, including all of the following:

(I) Cellular telephones and other safety tracking technology for child care fund-funded staff.

(II) Training for child care fund-funded staff and in-service education related to the in-home care component, excluding tuition grants or scholarships for college credit.

(III) Education costs for children who are prohibited from school attendance in a public school system or the local education agency or have severe educational issues and have been court ordered into a child care fund-funded educational program.

(IV) Printing, binding, or postage for materials relating to the education or correspondence on behalf of children in the in-home care program.

(V) Membership dues or fees – professional credential maintenance of staff who provide or support a service to children under the child care fund or professional staff for whom professional licensure is required in their respective job descriptions.

(VI) Business cards.

(F) Other program-specific activities costs, including entrance fees for programs.

(G) Conference travel costs for other non-child-care-fund-related training, including evidence-based and promising practices training.

(H) Contracted personnel, programming, or services, or any combination of these.

(I) Unit cost contracts, including all of the following:

(I) Contracted - drug testing – lab (per "drug test" basis).

(II) Contracted - counselor fees – (per "hour" basis).

(III) Contracted - group session dollar per session (per "session" basis). Group roster documentation required.

(IV) Contracted - psychological evaluations, excluding competency examinations – (per "evaluation" basis).

(V) Contracted - service providers (per "service" basis).

(J) Closed-end contracts. Closed-end contracts include, but are not limited to, all of the following:

(I) University contracts, including "program evaluation".

(II) Private agency services contracts.

(III) Educational services contracts.

(IV) Court appointed special advocate (CASA) and wraparound contracts.

(V) Other contracts identifiable to the program.

(K) Nonscheduled payments or case services payments. A nonscheduled payment is a payment to an individual or organization for items specified and defined in the child care fund handbook that are not included in the state-established per diem rate. A nonscheduled payment may include the following list:

(I) Emergency costs, including immediate food, clothing, medical, or dental needs that are not covered by another source.

(II) Gymnasium or other pro-social activity requiring a membership per child related to program activities.

(III) Rewards or incentive pay for youth related to program activities.

(IV) Bus tokens or gas cards related to program activities.

(V) Mentor costs - meals, mileage, movies, or social costs related to program activities.

(VI) Noncontracted service provider related to program activities.

(VII) Noncontracted group session related to program activities.

(VIII) Noncontracted psychological evaluations, excluding competency examinations.

(IX) Family assessment or evaluations.

(X) Noncontracted counselor fees.

(XI) Noncontracted drug testing – labs.

(XII) Camps or field trips.

(XIII) Birth certificates for children.

(L) New services that the department may agree with counties and tribes to include that are not identified

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in this section that support eligible children and families.

(M) Technology and software.

(*iv*) Administrative or indirect expenditures for in-home care. An administrative or indirect cost payment equal to 10% of a county's total monthly gross expenditures will automatically be distributed to the county on a monthly basis. A county is not required to submit documentation to the department for any of the expenditures that are covered under the 10% payment.

(c) The county amount distributed shall equal 50% of the annual expenditures from the child care fund of the county established under section 117c, except that expenditures under section 117c(3) and expenditures that exceed the amount of a budget approved under section 117c shall not be included. A distribution under this subdivision shall not be made to a county that does not comply with the requirements of this act. Subject to a county's approval, the department may reduce the amount distributed to a county by the amount owed to the state for care received in a state operated facility or for care received under 1935 PA 220, MCL 400.201 to 400.214, or under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309.

(d) For a county that is a county juvenile agency, a county's block grant amount as determined under section 117g in equal distributions on October 1, January 1, April 1, and July 1 of each state fiscal year.

(e) Notwithstanding the provisions in subdivision (a), subject to appropriations, the department shall pay 100% of the costs of the $9.20 increase to the administrative rate for providers of foster care services provided in the annual appropriation for the department budget. For the purposes of this subdivision only, "foster care" means 24-hour substitute care for children placed away from their parents or guardians, as a result of a court order under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, in placements supervised by the department or a private child placing agency under contract with the department for foster care services. Foster care services include supervision of placements in foster family homes, foster family group homes, and preadoptive placements.

(f) Notwithstanding the provisions of subdivision (c), the department shall pay 100% of the administrative rate that is in effect on September 26, 2018 for providers of treatment foster care services and foster care services provided in the annual appropriation for the department budget. For the purposes of this subdivision only, "foster care" means 24-hour substitute care for children placed away from their parents or guardians, as a result of a court order under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, in placements supervised by the department or a private child placing agency under contract with the department for foster care services. Foster care services include supervision of placements in foster family homes, foster family group homes, treatment foster care, preadoptive placements, and supervision of children reunified with the parent with whom the child lived at the time of removal.

(g) Notwithstanding the provisions in subdivision (c), the department shall pay 100% of the costs of any rate increase that is in effect on September 26, 2018 to the providers of residential foster care services under contract with the department, as provided in the annual appropriation for the department budget.

(h) Notwithstanding the provisions in subdivision (c) and subject to appropriations, the department shall implement a prospective payment system as part of a state-administered performance-based child welfare system in a county with a population of not less than 575,000 or more than 750,000, for foster care case management in accordance with section 503 of article X of 2014 PA 252. The county is only required to contribute to foster care services payments in an amount that does not exceed the average of the annual net contribution made by the county for cases received under section 2(b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, in the 5 previous fiscal years before October 1, 2015. The prospective payment system as part of the state-administered performance-based child welfare system shall be implemented as described in this subdivision but shall not include in-home care service funding.

(i) Subdivision (h) only impacts child abuse and child neglect services and not juvenile justice program funding.

(5) The purposes for which funding under this section shall be distributed as provided under subsection (4) may be allowed unless otherwise accessible and available by other public assistance programs necessary to achieve the goals and outcomes for in-home care or out-of-home care. Reimbursement shall not be made for costs associated with an otherwise eligible child or family, or both, if the reason for the unavailability of public assistance is due to intentional program violations and disqualification of any public assistance.

(6) All service providers shall submit a request for payment within 1 calendar year of the date of service. A request for payment submitted after 1 calendar year from the date of service requires the provider to submit an exception request to the county or the department for approval or denial.

(7) The county or the department is not subject to an offset, chargeback, or reimbursement liability when a child care fund cost is approved by the county or the department for payment after 1 year from the date of service.

(8) The county is not subject to an offset, chargeback, or reimbursement liability for prior expenditures

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resulting from an error in foster care fund source determinations.

(9) The department is liable for the costs of all juvenile justice services in a county that is a county juvenile agency other than county juvenile agency services.

(10) The department shall establish guidelines for the development of county juvenile justice service plans in counties that are not county juvenile agencies.

(11) A county that is not a county juvenile agency and receives state funds for in-home or out-of-home care of children shall submit reports to the department at least quarterly or as the department otherwise requires. The reports shall be submitted on forms provided by the executive director and shall include the number of children receiving foster care services and the number of days of care provided.

(12) The department shall maintain a reporting system providing that reimbursement under subsection (4)(c) shall be made only on submission of billings based on care given to a specific, individual child.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1980, Act 328, Imd. Eff. Dec. 19, 1980;—Am. 1988, Act 75, Eff. Oct. 1, 1988;—Am. 1998, Act 516, Imd. Eff. Jan. 12, 1999;—Am. 2013, Act 138, Imd. Eff. Oct. 15, 2013;—Am. 2014, Act 304, Imd. Eff. Oct. 9, 2014;—Am. 2014, Act 520, Imd. Eff. Jan. 14, 2015;—Am. 2015, Act 81, Eff. Oct. 1, 2015;—Am. 2016, Act 279, Eff. Oct. 1, 2016;—Am. 2017, Act 104, Eff. Oct. 11, 2017;—Am. 2018, Act 22, Eff. May 15, 2018;—Am. 2018, Act 244, Eff. Sept. 26, 2018;—Am. 2018, Act 580, Eff. Mar. 28, 2019.

Compiler's note: Section 3 of Act 75 of 1988 provides: "This amendatory act shall take effect June 1, 1988." This section was amended by Act 178 of 1988 to read as follows: "This amendatory act shall take effect October 1, 1988."

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.117b Office of children and youth services; powers generally.

Sec. 117b. The office may:

(a) Provide juvenile justice program planning and technical assistance to units of county and state government and to the private sector.

(b) Enter into agreements with the federal government, state, county, or municipal departments, or private foundations or trusts for the receipt of funds for purposes consistent with the powers and duties of the office, including subcontracts with the office of criminal justice programs to develop the state plan required by Public Law 93-415.

(c) Contract with state, county, or other public agencies or private corporations to provide training programs for service personnel or to provide services to children and youth.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.117c County treasurer as custodian of money; creation and maintenance of child care fund; deposits in fund; use of fund; separate account for fund; subaccounts; plan and budget for funding foster care services; records of juvenile justice services and expenditures; child care fund reimbursable claims; evidence of compliance with parameters; applicability of section to county juvenile agency.

Sec. 117c. (1) The county treasurer is designated as the custodian of all money provided for the use of the county department, the family division of circuit court, and the agency designated by the county board of commissioners or, if a county has a county executive, chief administrative officer, or county manager, that individual to provide juvenile justice services. The county treasurer shall create and maintain a child care fund. The following money shall be deposited in the child care fund:

(a) All money raised by the county for the use of the county department for the foster care of children with respect to whom the family division of circuit court has not taken jurisdiction.

(b) Money for the foster care of children under the jurisdiction of the family division of circuit court raised by the county with the view of receiving supplementary funds for this purpose from the state government as provided in section 117a.

(c) All funds made available by the state government for foster care of children.

(d) All payments made in respect to support orders issued by the family division of circuit court for the reimbursement of government for expenditures made or to be made from the child care fund for the foster care of children.

(e) All prepayments and refunds for reimbursement of county departments for the foster care of children.

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(f) Money for the foster care of children under the jurisdiction of the court of general criminal jurisdiction committed to a county facility or a court facility for juveniles in the county in which the court of general criminal jurisdiction is located.

(g) All payments made in respect to support orders issued by the court of general criminal jurisdiction for the reimbursement of government for expenditures made or to be made from the child care fund for the foster care of children.

(2) The child care fund shall be used for the costs of providing foster care for children under sections 18c and 117a and under the jurisdiction of the family division of circuit court or court of general criminal jurisdiction.

(3) The child care fund may be used to pay the county's share of the cost of maintaining children at the Michigan children's institute under 1935 PA 220, MCL 400.201 to 400.214, or public wards under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309.

(4) The account for the child care fund shall be maintained separate and apart from all other accounts of county funds. The fund shall be used exclusively for carrying out the purposes authorized by this act. The county board of commissioners shall distinguish in its appropriations for the child care fund the sums of money to be used by the family division of circuit court, the county department, and the agency designated by the county board of commissioners or the county executive to provide juvenile justice services. The county treasurer shall keep these segregated in proper subaccounts.

(5) A county annually shall develop and submit a plan and budget for the funding of foster care services for approval. Funds shall not be distributed under section 117a except for reimbursement of expenditures made under an approved plan and budget. Neither the department nor the county shall seek reimbursement for expenditures, except if those expenditures were made under an approved plan and budget or according to department policy.

(6) A county shall make and preserve accurate records of its juvenile justice services and expenditures. Upon the department's request, the information contained in the records shall be available to the office.

(7) Counties shall utilize and make available to the department, upon request, evidence of compliance with the following parameters with regard to child care fund reimbursable claims:

(a) Donated funds may be deposited into the county child care fund and are not subject to offset if either of the following applies:

(*i*) The donor is not the intended recipient of a contract to be funded by the donated funds.

(*ii*) The donor is an intended recipient of a contract to be funded by the donated funds and the donor is able to document the source of the money comprising the donated funds.

(b) The following conditions apply to requests for reimbursement of expenditures from the county's donated funds program:

(*i*) The county shall identify the donor of the funds and shall certify that the donor is not the recipient of a contract funded by the donated funds or the donor is the recipient of a contract funded by the donated funds and has documented the source of the money comprising the donated funds.

(*ii*) Donated funds shall be identified by donor, source of money comprising the donated funds, the date the money was provided to the donor, and the date the donated funds were deposited into the county child care fund.

(*iii*) The county must ensure transparency relating to service delivery by donor-funded providers. The county shall ensure donor-funded providers complete an annual certification of fund eligibility and shall make available to the department the solicitation, evaluation, and selection process of awarding a contract to a donor-funded provider.

(8) This section does not apply to a county that is a county juvenile agency.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1980, Act 328, Imd. Eff. Dec. 19, 1980;—Am. 1988, Act 75, Eff. Oct. 1, 1988;—Am. 1988, Act 223, Eff. Apr. 1, 1989;—Am. 1998, Act 516, Imd. Eff. Jan. 12, 1999;—Am. 2018, Act 21, Eff. May 15, 2018.

Compiler's note: Section 3 of Act 75 of 1988 provides: "This amendatory act shall take effect June 1, 1988." This section was amended by Act 178 of 1988 to read as follows: "This amendatory act shall take effect October 1, 1988."

For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.117d Repealed. 2018, Act 21, Eff. May 15, 2018.

Compiler's note: The repealed section pertained to allocation of funds to county juvenile justice services program.

Popular name: Act 280

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400.117e Annual basic grant of state money; eligibility; use of basic grant; criteria and conditions for basic grant; money for early intervention to treat problems of delinquency and neglect.

Sec. 117e. (1) A county having a population of less than 75,000 is eligible to receive an annual basic grant of state money of $15,000.00.

(2) To be eligible to receive state financial support under subsection (1), a county shall meet the requirements of this act. A county shall not be required to contribute matching funds to receive state financial support under subsection (1).

(3) A basic grant may be used only to supplement added juvenile justice service costs and shall not be used to replace county money currently being expended on juvenile justice services.

(4) The office shall establish qualifying criteria for awarding the basic grants and may specify conditions for each grant.

(5) To provide for early intervention to treat problems of delinquency and neglect within the child's home and to expedite a child's return to his or her home, the office may expend money from the child care fund or from other sources authorized in legislative appropriations for new or expanded programs, if the office determines that the programs are alternatives to out-of-home institutional or foster care. The office shall establish criteria for the approval of expenditures made under this subsection. The office shall submit to the legislature and the governor a report summarizing and evaluating the implementation of this subsection and containing recommendations for its future use.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1983, Act 222, Imd. Eff. Nov. 28, 1983;—Am. 2004, Act 193, Imd. Eff. July 8, 2004.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.117f Joint program for providing juvenile justice services.

Sec. 117f. Two or more adjoining counties may establish a joint program for providing juvenile justice services.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1983, Act 222, Imd. Eff. Nov. 28, 1983.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.117g County block grant; calculation; adjustment; deduction.

Sec. 117g. (1) The base amount of the block grant for a county that is a county juvenile agency equals the amount determined under subdivision (a) minus the amount determined under subdivision (b):

(a) The total of all distributions or expenditures from state or federal funds for the state fiscal year beginning October 1, 1997 for that county related to county juvenile agency services, including the following:

(*i*) That portion of the distribution to the county under section 117a for county juvenile agency services calculated without regard to any exclusion of expenditure on the basis that the expenditure exceeded the amount of a budget approved under section 117c.

(*ii*) Detention and assessment costs.

(*iii*) Community-based programs, including halfway house or day treatment.

(*iv*) Staff costs, including salaries and fringe benefits, for all employees employed to administer or deliver programs providing county juvenile agency services, including county juvenile officers, delinquency or service workers, and related supervisory, clerical, and administrative staff support. The staff costs of state employees shall be calculated using staff levels on March 30, 1997 as the staff levels for the entire state fiscal year.

(*v*) Operational expenses related to programs providing county juvenile agency services, including supplies, equipment, buildings, rent, training costs, and costs of the management information system.

(*vi*) The total cost of care for public wards under the youth rehabilitation services act, 1974 PA 150, MCL 803.301 to 803.309.

(b) One-half of the amount of state and county expenditures charged to the county's child care fund for juvenile justice services provided in the state fiscal year beginning October 1, 1997 that were not county juvenile agency services, without regard to any exclusion of expenditure on the basis that the expenditure exceeded the amount of a budget approved under section 117c.

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(2) For the state fiscal year beginning October 1, 1999, the base amount for a county shall be adjusted by both of the multipliers calculated under subsection (3) to determine the block grant amount for that state fiscal year. The block grant amount for each subsequent state fiscal year is calculated by adjusting the block grant amount for the previous state fiscal year by the multipliers calculated under subsection (3).

(3) For each state fiscal year, the following multipliers shall be calculated:

(a) The percentage change appropriated in that state fiscal year to change the rate of payments to vendors providing placements for juveniles for that state fiscal year from the previous state fiscal year.

(b) The percentage change in the county's juvenile population from the county's juvenile population for the previous fiscal year as determined from the United States decennial census or projections by the United States census bureau. As used in this subdivision, "county's juvenile population" means the number of individuals residing in the county who are 10 or more years of age but less than 18 years of age.

(4) The calculations under subsections (2) and (3) apply regardless of the state fiscal year in which a county becomes a county juvenile agency.

(5) A block grant for a county determined under subsections (1) to (4) for a state fiscal year shall be reduced by the amount calculated by subtracting the amount determined under subdivision (a) from the amount determined under subdivision (b) and multiplying that difference by 50% of the per-child cost for educational services to state wards in state operated training schools and treatment and detention facilities during the state fiscal year beginning October 1, 1998:

(a) The average daily population of public wards in state operated training schools and treatment and detention facilities for whom the county has assumed responsibility as a county juvenile agency.

(b) The average daily population of public wards for the county.

(6) Fifty percent of the amount of block grant funds expended during the state fiscal year for educational services to public wards for whom the county has assumed responsibility as a county juvenile agency shall be deducted from the amount calculated under subsection (5).

History: Add. 1998, Act 516, Imd. Eff. Jan. 12, 1999.

Popular name: Act 280

400.117h Appeal.

Sec. 117h. (1) The department or a county may appeal a determination regarding reimbursement of a child care cost made under this act. The appeal shall be conducted according to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(2) An appeal from a final order issued in an administrative hearing shall be made to the circuit court of Ingham County, which court has jurisdiction with respect to the cases described in subsection (1) as in nonjury cases under the authority provided in section 631 of the revised judicature act of 1961, 1961 PA 236, MCL 600.631.

History: Add. 2018, Act 21, Eff. May 15, 2018.

Popular name: Act 280

400.118 Youth advisory commission; creation; appointment, qualifications, terms, and compensation of members.

Sec. 118. (1) A youth advisory commission is created within the office to consist of 7 members appointed by the governor with the advice and consent of the senate. Not more than 4 of the members shall be from the same political party. Members shall be appointed for terms of 4 years and shall serve until their successors are appointed and qualified.

(2) The per diem compensation of the advisory commission and the schedule for reimbursement of expenses shall be established annually by the legislature.

History: Add. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.119 Youth advisory commission; duties.

Sec. 119. (1) The youth advisory commission shall:

(a) Provide the executive director of the office with advice and recommendations concerning the formulation and implementation of programs and policies administered by the office.

(b) Inform the legislature, the executive office, the judiciary, and the public of the needs and interests of children and the programs and needs of the office.

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(2) The youth advisory commission shall cooperate with the office and the office of criminal justice programs in the development of the state plan required by Public Law 93-415, 5 U.S.C. 5108; 18 U.S.C. 4351 to 4353, 5031 to 5042; and 42 U.S.C. 3701, 3723, 3733, 3768, 3772 to 3774, 3811 to 3814, 3821, 3882, 3883, 3888, and 5601 to 5751.

History: Add. 1969, Act 338, Imd. Eff. Dec. 8, 1969;—Am. 1972, Act 301, Eff. Jan. 1, 1973;—Am. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.119a Departments and agencies of executive branch of government; duties.

Sec. 119a. Departments and agencies of the executive branch of government shall:

(a) Cooperate with the office in the development of plans, budgets, programs, and evaluations pertaining to children and youth services and programs.

(b) Provide the executive director with information and reports required in the administration of the responsibilities of the office.

(c) Conform to any directives or orders of the governor pertaining to the coordination, establishment, consolidation, continuation, or revision of children and youth services and programs.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.119b Report by office to governor and legislature; contents; review of effectiveness of office; report and recommendations.

Sec. 119b. (1) Not later than August 1, 1978, the office shall make a written report to the governor and legislature setting forth principal objectives of the office for the next 2 years, which relate to its program goals and administrative responsibilities. The office shall also establish a basis for the measurement of its effectiveness.

(2) A thorough, independent review of the effectiveness of the office shall be initiated by the governor in March 1981 to be completed with a report and recommendations to the legislature and governor not later than March 1982. This review shall take into account and assess, but shall not be limited to, the following:

(a) The need for further change in the system of delivering and administering children and youth services.

(b) Existing statutes and rules affecting children and youth.

(c) Advancement toward the prevention of delinquency, neglect, alienation, and child abuse, and the provision of least detrimental dispositional alternatives for children and youth in trouble or at risk.

(d) The effectiveness of the office in insuring equity in the availability of services and the protection of the rights of children and youth.

(e) The effectiveness of the office in establishing standards of uniform practice of children and youth services.

(f) The budgetary adequacy and utilization of funds, including the administration of title 20 of the social security act, 42 U.S.C. 1397 to 1397f, and juvenile justice services fund.

(g) Coordination of services in the public and private sectors and the judiciary.

(h) The development and implementation of an information system.

(i) Research on the problems of and services to children and youth.

(j) The development of a network of regional detention and shelter care.

(k) The option to transfer services staff from the judicial branch to the office.

(*l*) Policy development and leadership.

(m) The need to continue, terminate, or modify the status and function of the office as established by this act.

History: Add. 1978, Act 87, Eff. Apr. 1, 1978;—Am. 1980, Act 155, Imd. Eff. June 12, 1980.

Compiler's note: For transfer of powers and duties of the Office of Children and Youth Services as a single-purpose entity within the Department of Social Services to the Department of Social Services, see E.R.O. No. 1991-8, compiled at MCL 400.221 of the Michigan Compiled Laws.

Popular name: Act 280

400.120, 400.121 Repealed. 1988, Act 75, Eff. June 1, 1991.

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Compiler's note: The repealed sections pertained to the youth parole and review board.

Popular name: Act 280

400.122 Repealed. 1978, Act 87, Eff. Apr. 1, 1978.

Compiler's note: The repealed section pertained to additional duties of chief administrator.

Popular name: Act 280

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