

Act No. 60
Public Acts of 2001
Approved by the Governor*
July 23, 2001
Filed with the Secretary of State
July 24, 2001
EFFECTIVE DATE: July 24, 2001

*Item Vetoes

Sec. 112. COMMUNITY LIVING, CHILDREN, AND FAMILIES

Early childhood collaborative secondary prevention..... \$ 1,750,000 (Page 5)

Sec. 117. OFFICE OF SERVICES TO THE AGING

Senior Olympics \$ 100,000 (Page 7)

Sec. 224.

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**STATE OF MICHIGAN
91ST LEGISLATURE
REGULAR SESSION OF 2001**

**Introduced by Reps. Mortimer, LaSata, Mead, Newell, Stamas, Vander Roest, Jansen, Kooiman, Pappageorge,
Cameron Brown and Shulman**

ENROLLED HOUSE BILL No. 4254

AN ACT to make appropriations for the department of community health and certain state purposes related to mental health, public health, and medical services for the fiscal year ending September 30, 2002; to make, supplement, and adjust appropriations for certain projects for the fiscal year ending September 30, 2001; to provide for the expenditure of those appropriations; to create funds; to require and provide for reports; to prescribe the powers and duties of certain local and state agencies and departments; and to provide for disposition of fees and other income received by the various state agencies.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS - FISCAL YEAR 2001-2002

Sec. 101. Subject to the conditions set forth in this act, the amounts listed in this part are appropriated for the department of community health for the fiscal year ending September 30, 2002, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH

Full-time equated unclassified positions	6.0	
Full-time equated classified positions	6,201.1	
Average population	1,508.0	
GROSS APPROPRIATION		\$ 8,670,728,100
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		\$ 74,507,400
ADJUSTED GROSS APPROPRIATION		\$ 8,596,220,700
Federal revenues:		
Total federal revenues		4,464,845,500
Special revenue funds:		
Total local revenues		1,063,251,900
Total private revenues		63,585,600
Total local and private revenues		1,126,837,500
Tobacco settlement revenue		98,046,000
Total other state restricted revenues		252,818,500
State general fund/general purpose		\$ 2,653,673,200

Sec. 102. DEPARTMENTWIDE ADMINISTRATION

Full-time equated unclassified positions	6.0	
Full-time equated classified positions	514.7	
Director and other unclassified—6.0 FTE positions		\$ 581,500
Community health advisory council		28,900
Departmental administration and management—491.7 FTE positions.....		56,197,100
Certificate of need program administration—13.0 FTE positions		938,300
Worker's compensation program—1.0 FTE position.....		11,504,000
Rent and building occupancy		8,796,200
Developmental disabilities council and projects—9.0 FTE positions		2,749,500
Rural health services		681,500
GROSS APPROPRIATION		\$ 81,477,000
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of treasury, Michigan state hospital finance authority.....		100,700
Federal revenues:		
Total federal revenues		25,183,600
Special revenue funds:		
Total private revenues.....		35,900
Total other state restricted revenues		3,571,600
State general fund/general purpose		\$ 52,585,200

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

Full-time equated classified positions	112.0	
Mental health/substance abuse program administration—112.0 FTE positions.....		\$ 11,050,000
Consumer involvement program		189,100
Gambling addiction		3,500,000
Protection and advocacy services support		818,300
Mental health initiatives for older persons		1,165,800
Community residential and support services		4,969,300
Highway safety projects		1,837,200
Federal and other special projects		1,977,200
GROSS APPROPRIATION		\$ 25,506,900
Appropriated from:		
Federal revenues:		
Total federal revenues		5,799,200
Special revenue funds:		
Total private revenues.....		160,000
Total other state restricted revenues		3,682,300
State general fund/general purpose		\$ 15,865,400

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

Full-time equated classified positions	4.0	
Medicaid mental health services		\$ 1,196,433,900
Community mental health non-Medicaid services		313,823,200
Multicultural services		3,848,000
Medicaid substance abuse services.....		24,851,700
Respite services		3,318,600
CMHSP, purchase of state services contracts		170,157,400
Civil service charges		2,606,400
Federal mental health block grant—2.0 FTE positions		11,546,700
Pilot projects in prevention for adults and children—2.0 FTE positions		996,300
State disability assistance program substance abuse services		6,600,000
Community substance abuse prevention, education and treatment programs		83,740,400
GROSS APPROPRIATION		\$ 1,817,922,600

Appropriated from:	
Federal revenues:	
Total federal revenues	\$ 763,469,800
Special revenue funds:	
Total other state restricted revenues	6,342,400
State general fund/general purpose	\$ 1,048,110,400

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

Total average population	1,508.0	
Full-time equated classified positions	4,650.0	
Caro regional mental health center - psychiatric hospital - adult—479.0 FTE positions		\$ 34,687,500
Average population	180.0	
Kalamazoo psychiatric hospital - adult—397.0 FTE positions		29,262,400
Average population	140.0	
Northville psychiatric hospital - adult—833.0 FTE positions		62,715,300
Average population	370.0	
Walter P. Reuther psychiatric hospital - adult—456.0 FTE positions		34,928,800
Average population	230.0	
Hawthorn center - psychiatric hospital - children and adolescents—328.0 FTE positions		23,751,800
Average population	118.0	
Mount Pleasant center - developmental disabilities—490.0 FTE positions		34,196,200
Average population	200.0	
Southgate center - developmental disabilities—201.0 FTE positions		14,630,300
Average population	60.0	
Center for forensic psychiatry—522.0 FTE positions		41,008,600
Average population	210.0	
Forensic mental health services provided to the department of corrections—		
938.0 FTE positions		73,796,000
Revenue recapture		750,000
IDEA, federal special education		120,000
Special maintenance and equipment		879,000
Purchase of medical services for residents of hospitals and centers		1,358,200
Closed site, transition, and related costs—6.0 FTE positions		565,700
Severance pay		696,000
Gifts and bequests for patient living and treatment environment		2,000,000
GROSS APPROPRIATION	\$	355,345,800

Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from the department of corrections	73,796,000
Federal revenues:	
Total federal revenues	39,252,000
Special revenue funds:	
CMHSP, purchase of state services contracts	170,157,400
Other local revenues	17,171,100
Total private revenues	2,000,000
Total other state restricted revenues	11,189,700
State general fund/general purpose	\$ 41,779,600

Sec. 106. PUBLIC HEALTH ADMINISTRATION

Full-time equated classified positions	88.3	
Executive administration—15.5 FTE positions		\$ 1,390,100
Minority health grants and contracts		1,089,100
Vital records and health statistics—72.8 FTE positions		6,588,400
GROSS APPROPRIATION	\$	9,067,600

Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from family independence agency	138,800

For Fiscal Year
Ending Sept. 30,
2002

Federal revenues:		
Total federal revenues	\$	2,835,200
Special revenue funds:		
Total other state restricted revenues		2,386,100
State general fund/general purpose	\$	3,707,500

Sec. 107. INFECTIOUS DISEASE CONTROL

Full-time equated classified positions	44.3	
AIDS prevention, testing and care programs—9.8 FTE positions	\$	24,399,400
Immunization local agreements		13,990,300
Immunization program management and field support—7.7 FTE positions		1,696,800
Sexually transmitted disease control local agreements		2,896,700
Sexually transmitted disease control management and field support—26.8 FTE positions		2,993,000
GROSS APPROPRIATION	\$	45,976,200
Appropriated from:		
Federal revenues:		
Total federal revenues		32,003,800
Special revenue funds:		
Total private revenues		925,000
Total other state restricted revenues		6,968,000
State general fund/general purpose	\$	6,079,400

Sec. 108. LABORATORY SERVICES

Full-time equated classified positions	118.2	
Laboratory services—118.2 FTE positions	\$	12,395,200
GROSS APPROPRIATION	\$	12,395,200
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from environmental quality		391,300
Federal revenues:		
Total federal revenues		1,892,800
Special revenue funds:		
Total other state restricted revenues		3,370,300
State general fund/general purpose	\$	6,740,800

Sec. 109. EPIDEMIOLOGY

Full-time equated classified positions	31.5	
AIDS surveillance and prevention program—7.0 FTE positions	\$	1,772,800
Epidemiology administration—24.5 FTE positions		5,162,500
Tuberculosis control and recalcitrant AIDS program		498,300
GROSS APPROPRIATION	\$	7,433,600
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of environmental quality		80,600
Federal revenues:		
Total federal revenues		4,716,100
Special revenue funds:		
Total other state restricted revenues		234,100
State general fund/general purpose	\$	2,402,800

Sec. 110. LOCAL HEALTH ADMINISTRATION AND GRANTS

Full-time equated classified positions	3.0	
Implementation of 1993 PA 133, MCL 333.17015	\$	100,000
Lead abatement program—3.0 FTE positions		1,945,300
Local health services		512,300
Local public health operations		41,070,200
Medical services cost reimbursement to local health departments		1,500,000
GROSS APPROPRIATION	\$	45,127,800

Appropriated from:		
Federal revenues:		
Total federal revenues	\$	3,345,300
Special revenue funds:		
Total other state restricted revenues		343,500
State general fund/general purpose	\$	41,439,000

Sec. 111. CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Full-time equated classified positions	33.7	
AIDS and risk reduction clearinghouse and media campaign	\$	1,576,000
Alzheimer's information network		440,000
Cancer prevention and control program—13.6 FTE positions		13,905,700
Chronic disease prevention		1,767,400
Diabetes and kidney program—9.0 FTE positions		4,471,900
Employee wellness program grants		4,259,300
Health education, promotion, and research programs—2.9 FTE positions		1,432,900
Injury control intervention project		1,032,800
Michigan Parkinson's Foundation		200,000
Morris Hood Wayne State University diabetes outreach		500,000
Physical fitness, nutrition, and health		1,375,000
Public health traffic safety coordination		415,000
School health and education programs		3,282,800
Smoking prevention program—6.2 FTE positions		8,500,000
Tobacco tax collection and enforcement		810,000
Violence prevention—2.0 FTE positions		3,456,800
GROSS APPROPRIATION	\$	47,425,600
Appropriated from:		
Federal revenues:		
Total federal revenues		13,568,300
Special revenue funds:		
Total other state restricted revenues		25,225,600
State general fund/general purpose	\$	8,631,700

Sec. 112. COMMUNITY LIVING, CHILDREN, AND FAMILIES

Full-time equated classified positions	88.8	
Adolescent and child health care services	\$	5,242,300
Childhood lead program—5.0 FTE positions		1,408,200
Children's waiver home care program		22,828,400
Community living, children, and families administration—73.3 FTE positions		7,776,700
Dental programs		510,400
Dental program for persons with developmental disabilities		151,000
Early childhood collaborative secondary prevention		1,750,000
Family planning local agreements		8,393,900
Family support subsidy		14,563,500
Housing and support services—1.0 FTE position		5,032,900
Local MCH services		9,050,200
Medicaid outreach and service delivery support		8,488,600
Migrant health care		200,000
Newborn screening follow-up and treatment services		2,428,000
Omnibus budget reconciliation act implementation—9.0 FTE positions		12,769,400
Pediatric AIDS prevention and control		1,026,300
Pregnancy prevention program		7,196,100
Prenatal care outreach and service delivery support		4,299,300
Southwest community partnership		1,547,300
Special projects—0.5 FTE position		5,658,900
Sudden infant death syndrome program		321,300
GROSS APPROPRIATION	\$	120,642,700

For Fiscal Year
Ending Sept. 30,
2002

Appropriated from:		
Federal revenues:		
Total federal revenues	\$	72,345,300
Special revenue funds:		
Total private revenues.....		261,100
Total other state restricted revenues		7,839,100
State general fund/general purpose	\$	40,197,200

Sec. 113. WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAMS

Full-time equated classified positions	42.0	
Women, infants, and children program administration and special projects—		
42.0 FTE positions.....	\$	5,206,300
Women, infants, and children program local agreements and food costs		164,311,000
GROSS APPROPRIATION	\$	169,517,300
Appropriated from:		
Federal revenues:		
Total federal revenues		121,741,400
Special revenue funds:		
Total private revenues.....		47,775,900
State general fund/general purpose	\$	0

Sec. 114. CHILDREN'S SPECIAL HEALTH CARE SERVICES

Full-time equated classified positions	66.6	
Children's special health care services administration—66.6 FTE positions	\$	5,365,200
Amputee program		184,600
Bequests for care and services.....		1,579,600
Case management services		3,923,500
Conveyor contract		559,100
Medical care and treatment.....		118,249,000
GROSS APPROPRIATION	\$	129,861,000
Appropriated from:		
Federal revenues:		
Total federal revenues		63,836,700
Special revenue funds:		
Total private revenues.....		750,000
Total other state restricted revenues		650,000
State general fund/general purpose	\$	64,624,300

Sec. 115. OFFICE OF DRUG CONTROL POLICY

Full-time equated classified positions	17.0	
Drug control policy—17.0 FTE positions.....	\$	1,964,800
Anti-drug abuse grants		28,659,200
GROSS APPROPRIATION	\$	30,624,000
Appropriated from:		
Federal revenues:		
Total federal revenues		30,238,000
State general fund/general purpose	\$	386,000

Sec. 116. CRIME VICTIM SERVICES COMMISSION

Full-time equated classified positions	9.0	
Grants administration services—9.0 FTE positions	\$	1,162,700
Justice assistance grants		15,000,000
Crime victim rights services grants.....		8,405,300
GROSS APPROPRIATION	\$	24,568,000
Appropriated from:		
Federal revenues:		
Total federal revenues		15,841,400

Special revenue funds:		
Total other state restricted revenues	\$	8,209,700
State general fund/general purpose	\$	516,900

Sec. 117. OFFICE OF SERVICES TO THE AGING

Full-time equated classified positions	40.5	
Commission (per diem \$50.00)	\$	10,500
Long-term care advisor—3.0 FTE positions		3,046,000
Office of services to aging administration—37.5 FTE positions		4,262,800
Community services		32,778,400
Nutrition services		36,861,000
Senior volunteer services		6,000,000
Senior citizen centers staffing and equipment		2,140,700
Employment assistance		2,770,000
Respite care program		7,100,000
Senior Olympics		100,000
GROSS APPROPRIATION	\$	95,069,400
Appropriated from:		
Federal revenues:		
Total federal revenues		46,366,700
Special revenue funds:		
Total private revenues		125,000
Tobacco settlement revenue		8,046,000
Total other state restricted revenues		2,600,000
State general fund/general purpose	\$	37,931,700

Sec. 118. MEDICAL SERVICES ADMINISTRATION

Full-time equated classified positions	337.5	
Medical services administration—335.7 FTE positions	\$	47,100,500
Data processing contractual services		100
Facility inspection contract - state police		132,800
MIChild administration		3,327,800
Michigan essential health care provider		1,500,000
Palliative and end of life care		316,200
Primary care services—1.8 FTE positions		4,102,400
GROSS APPROPRIATION	\$	56,479,800
Appropriated from:		
Federal revenues:		
Total federal revenues		35,191,100
Special revenue funds:		
Total private revenues		40,000
Total other state restricted revenues		500,000
State general fund/general purpose	\$	20,748,700

Sec. 119. MEDICAL SERVICES

Hospital services and therapy	\$	691,613,000
Hospital disproportionate share payments		45,000,000
Physician services		144,916,000
Medicare premium payments		139,506,000
Pharmaceutical services		530,170,300
Home health services		27,108,000
Transportation		6,553,000
Auxiliary medical services		82,008,000
Ambulance services		6,000,000
Long-term care services		1,190,349,000
Elder prescription insurance coverage		50,000,700
Health plan services		1,252,637,000
MIChild outreach		3,327,800

		For Fiscal Year Ending Sept. 30, 2002
MIChild program	\$	57,067,100
Personal care services		30,329,400
Maternal and child health.....		9,234,500
Adult home help.....		158,781,400
Social services to the physically disabled.....		1,344,900
Subtotal basic medical services program		4,425,946,100
Wayne county medical program		44,012,800
School based services.....		65,094,200
State and local medical programs.....		80,899,900
Special adjustor payments		994,057,000
Subtotal special medical services payments		1,184,063,900
GROSS APPROPRIATION	\$	5,610,010,000
Appropriated from:		
Federal revenues:		
Total federal revenues		3,187,218,800
Special revenue funds:		
Total local revenues		875,923,400
Total private revenues.....		11,512,700
Tobacco settlement revenue		90,000,000
Total other state restricted revenues		169,706,100
State general fund/general purpose	\$	1,275,649,000
 Sec. 120. BUDGETARY SAVINGS		
Budgetary savings.....	\$	(13,722,400)
GROSS APPROPRIATION	\$	(13,722,400)
Appropriated from:		
State general fund/general purpose	\$	(13,722,400)

PART 2

PROVISIONS CONCERNING APPROPRIATIONS FOR FISCAL YEAR 2001-2002

GENERAL SECTIONS

Sec. 201. Pursuant to section 30 of article IX of the state constitution of 1963, total state spending from state resources under part 1 for fiscal year 2001-2002 is \$3,004,537,700.00 and state spending from state resources to be paid to local units of government for fiscal year 2001-2002 is \$997,238,400.00. The itemized statement below identifies appropriations from which spending to units of local government will occur:

DEPARTMENT OF COMMUNITY HEALTH

DEPARTMENTWIDE ADMINISTRATION

Departmental administration and management.....	\$	15,656,500
Rural health services		35,000

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Mental health initiatives for older persons		1,165,800
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COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Pilot projects in prevention for adults and children		915,700
State disability assistance program substance abuse services		6,600,000
Community substance abuse prevention, education, and treatment programs		18,673,500
Medicaid mental health services.....		522,124,100
Community mental health non-Medicaid services		313,823,200
Multicultural services		3,848,000
Medicaid substance abuse services.....		10,845,300
Respite services		3,318,600

INFECTIOUS DISEASE CONTROL	
AIDS prevention, testing and care programs	\$ 1,466,800
Immunization local agreements	2,973,900
Sexually transmitted disease control local agreements.....	452,900
LOCAL HEALTH ADMINISTRATION AND GRANTS	
Local public health operations.....	41,070,200
CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION	
Cancer prevention and control program	722,400
Diabetes and kidney program	909,000
Employee wellness program grants.....	2,321,100
School health and education programs	3,164,000
Smoking prevention program.....	1,380,800
COMMUNITY LIVING, CHILDREN, AND FAMILIES	
Adolescent and child health care services	1,361,600
Childhood lead program	85,000
Family planning local agreements.....	1,301,400
Local MCH services	246,100
Omnibus budget reconciliation act implementation	2,152,700
Pregnancy prevention program	3,169,600
Prenatal care outreach and service delivery support	1,235,000
CHILDREN'S SPECIAL HEALTH CARE SERVICES	
Case management services	3,319,900
MEDICAL SERVICES	
Transportation.....	866,200
OFFICE OF SERVICES TO THE AGING	
Community services.....	13,292,900
Nutrition services.....	12,848,500
Senior volunteer services.....	841,400
CRIME VICTIM SERVICES COMMISSION	
Crime victim rights services grants.....	<u>5,051,300</u>
TOTAL OF PAYMENTS TO LOCAL UNITS OF GOVERNMENT	\$ 997,238,400

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

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

Sec. 203. As used in this act:

- (a) "ACCESS" means Arab community center for economic and social services.
- (b) "AIDS" means acquired immunodeficiency syndrome.
- (c) "CMHSP" means a community mental health service program as that term is defined in section 100a of the mental health code, 1974 PA 258, MCL 330.1100a.
- (d) "DAG" means the United States department of agriculture.
- (e) "Disease management" means a comprehensive system that incorporates the patient, physician, and health plan into 1 system with the common goal of achieving desired outcomes for patients.
- (f) "Department" means the Michigan department of community health.
- (g) "DSH" means disproportionate share hospital.
- (h) "EPIC" means elder prescription insurance coverage program.
- (i) "EPSDT" means early and periodic screening, diagnosis, and treatment.
- (j) "FTE" means full-time equated.
- (k) "GME" means graduate medical education.

(l) "HIV" means human immunodeficiency virus.

(m) "HMO" means health maintenance organization.

(n) "IDEA" means individual disability education act.

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

(p) "MSS/ISS" means maternal and infant support services.

(q) "OBRA" means the omnibus budget reconciliation act of 1987, Public Law 100-203, 101 Stat. 1330.

(r) "Qualified health plan" means, at a minimum, an organization that meets the criteria for delivering the comprehensive package of services under the department's comprehensive health plan.

(s) "Title XVIII" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

(t) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6, and 1396r-8 to 1396v.

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

Sec. 204. The department of civil service shall bill departments and agencies at the end of the first fiscal quarter for the 1% charge authorized by section 5 of article XI of the state constitution of 1963. Payments shall be made for the total amount of the billing by the end of the second fiscal quarter.

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

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

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

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

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

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

Sec. 207. At least 120 days before beginning any effort to privatize, the department shall submit a complete project plan to the appropriate senate and house of representatives appropriations subcommittees and the senate and house fiscal agencies. The plan shall include the criteria under which the privatization initiative will be evaluated. The evaluation shall be completed and submitted to the appropriate senate and house of representatives appropriations subcommittees and the senate and house fiscal agencies within 30 months.

Sec. 208. Unless otherwise specified, the department shall use the Internet to fulfill the reporting requirements of this act. This may include transmission of reports via electronic mail to the recipients identified for each reporting requirement or it may include placement of reports on the Internet or Intranet site. Quarterly, the department shall provide to the house of representatives and senate appropriations subcommittees' members, the state budget office, and the house and senate fiscal agencies an electronic and paper listing of the reports submitted during the most recent 3-month period along with the Internet or Intranet site of each report, if any.

Sec. 209. (1) Funds appropriated in part 1 shall not be used for the purchase of foreign goods or services, or both, if competitively priced and comparable quality American goods or services, or both, are available.

(2) Funds appropriated in part 1 shall not be used for the purchase of out-of-state goods or services, or both, if competitively priced and comparable quality Michigan goods or services, or both, are available.

Sec. 210. (1) The director shall take all reasonable steps to ensure businesses in deprived and depressed communities compete for and perform contracts to provide services or supplies, or both. The director shall strongly encourage firms with which the department contracts to subcontract with certified businesses in depressed and deprived communities for services, supplies, or both.

(2) The director shall take all reasonable steps to ensure equal opportunity for all who compete for and perform contracts to provide services or supplies, or both, for the department. The director shall strongly encourage firms with which the department contracts to provide equal opportunity for subcontractors to provide services or supplies, or both.

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

Sec. 212. (1) From the amounts appropriated in part 1, no greater than the following amounts are supported with federal maternal and child health block grant, preventive health and health services block grant, substance abuse block grant, healthy Michigan fund, and Michigan health initiative funds:

(a) Maternal and child health block grant.....	\$	20,627,000
(b) Preventive health and health services block grant.....		6,115,300
(c) Substance abuse block grant		61,371,200
(d) Healthy Michigan fund.....		35,167,400
(e) Michigan health initiative.....		9,797,000

(2) On or before February 1, 2002, the department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on the detailed name and amounts of federal, restricted, private, and local sources of revenue that support the appropriations in each of the line items in part 1 of this act.

(3) Upon the release of the fiscal year 2002-2003 executive budget recommendation, the department shall report to the same parties in subsection (2) on the amounts and detailed sources of federal, restricted, private, and local revenue proposed to support the total funds appropriated in each of the line items in part 1 of the fiscal year 2002-2003 executive budget proposal.

(4) The department shall provide to the same parties in subsection (2) all revenue source detail for consolidated revenue line item detail upon request to the department.

Sec. 213. The state departments, agencies, and commissions receiving tobacco tax funds from part 1 shall report by November 1, 2001, to the senate and house of representatives appropriations committees, the senate and house fiscal agencies, and the state budget director on the following:

- (a) Detailed spending plan by appropriation line item including description of programs.
- (b) Allocations from funds appropriated under these sections.
- (c) Description of allocations or bid processes including need or demand indicators used to determine allocations.
- (d) Eligibility criteria for program participation and maximum benefit levels where applicable.
- (e) Outcome measures to be used to evaluate programs.
- (f) Any other information considered necessary by the house of representatives or senate appropriations committees or the state budget director.

Sec. 214. The use of state restricted tobacco tax revenue received for the purpose of tobacco prevention, education, and reduction efforts and deposited in the healthy Michigan fund shall not be used for lobbying as defined in 1978 PA 472, MCL 4.411 to 4.431.

Sec. 215. (1) The negative appropriation for budgetary savings in part 1 shall be satisfied by savings from the hiring freeze imposed in section 205 and, if necessary, by other savings identified by the department director and approved by the state budget director.

(2) Appropriation authorizations shall be adjusted after the approval of transfers by the legislature pursuant to section 393(2) of the management and budget act, 1984 PA 431, MCL 18.1393.

Sec. 216. (1) In addition to funds appropriated in part 1 for all programs and services, there is appropriated for write-offs of accounts receivable, deferrals, and for prior year obligations in excess of applicable prior year appropriations, an amount equal to total write-offs and prior year obligations, but not to exceed amounts available in prior year revenues.

(2) The department's ability to satisfy appropriation deductions in part 1 shall not be limited to collections and accruals pertaining to services provided in fiscal year 2001-2002, but shall also include reimbursements, refunds, adjustments, and settlements from prior years.

(3) The department shall report by March 15, 2002 and September 15, 2002 to the house of representatives and senate appropriations subcommittees on community health on all reimbursements, refunds, adjustments, and settlements from prior years.

Sec. 218. Basic health services for the purpose of part 23 of the public health code, 1978 PA 368, MCL 333.2301 to 333.2321, are: immunizations, communicable disease control, sexually transmitted disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, screening newborns for the 7 conditions listed in section 5431(1)(a) through (g) of the public health code, 1978 PA 368, MCL 333.5431, community health annex of the Michigan emergency management plan, and prenatal care.

Sec. 219. (1) The department may contract with the Michigan public health institute for the design and implementation of projects and for other public health related activities prescribed in section 2611 of the public health code, 1978 PA 368, MCL 333.2611. The department may develop a master agreement with the institute to carry out these purposes for up to a 3-year period. The department shall report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on or before November 1, 2001 and May 1, 2002 all of the following:

(a) A detailed description of each funded project.

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

(c) The expected project duration.

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

(2) If a report required under subsection (1) is not received by the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on or before the date specified for that report, the disbursement of funds to the Michigan public health institute under this section shall stop. The disbursement of those funds shall recommence when the overdue report is received.

(3) On or before September 30, 2002, the department shall provide to the same parties listed in subsection (1) a copy of all reports, studies, and publications produced by the Michigan public health institute, its subcontractors, or the department with the funds appropriated in part 1 and allocated to the Michigan public health institute.

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

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

Sec. 224. (1) If there is an increase in the \$9,270,300,000.00 estimate of fiscal year 2001-2002 state general fund/general purpose revenue from the May 2001 consensus revenue estimating conference to the January 2002 consensus revenue estimating conference, the increase in fiscal year 2001-2002 revenue, up to the amount of difference between the general fund/general purpose funding level contained in the original governor's recommendation for the fiscal year 2001-2002 department budget appropriation bill and the amount of general fund/general purpose funding contained in this bill as enacted, shall be appropriated to the department.

(2) The amount appropriated for the department pursuant to subsection (1) shall be used to restore services that may have been cut or reduced as a result of the reduction in general fund/general purpose funding for fiscal year 2001-2002 department budget due to the estimated amount of general fund/general purpose revenue available for fiscal year 2001-2002 and to increase payment rates for Medicaid and other providers of direct services to the department, allocated as a fixed percentage based on the amount of funds available, but not to exceed 2%.

DEPARTMENTWIDE ADMINISTRATION

Sec. 301. From funds appropriated for worker's compensation, the department may make payments in lieu of worker's compensation payments for wage and salary and related fringe benefits for employees who return to work under limited duty assignments.

Sec. 302. Funds appropriated in part 1 for the community health advisory council may be used for member per diems of \$50.00 and other council expenditures.

Sec. 303. The department is prohibited from requiring first-party payment from individuals or families with a taxable income of \$10,000.00 or less for mental health services for determinations made in accordance with section 818 of the mental health code, 1974 PA 258, MCL 330.1818.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Sec. 350. The department may enter into a contract with the protection and advocacy service, authorized under section 931 of the mental health code, 1974 PA 258, MCL 330.1931, or a similar organization to provide legal services for purposes of gaining and maintaining occupancy in a community living arrangement which is under lease or contract with the department or a community mental health services program to provide services to persons with mental illness or developmental disability.

Sec. 352. From the funds appropriated, the department shall conduct a statewide survey of adolescent suicide and assessment of available preventative resources.

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Sec. 401. (1) Funds appropriated in part 1 are intended to support a system of comprehensive community mental health services under the full authority and responsibility of local CMHSPs. The department shall ensure that each CMHSP provides all of the following:

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

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

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

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

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

(f) A system of continuous quality improvement.

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

(h) A system that serves at-risk and delinquent youth as required under the provisions of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(2) In partnership with CMHSPs, the department shall establish a process to ensure the long-term viability of a single entry and exit and locally controlled community mental health system.

(3) A contract between a CMHSP and the department shall not be altered or modified without a prior written agreement of the parties to the contract.

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

entered into under this subsection for fiscal year 2001-2002 does not exceed the amount of money appropriated in part 1 for the contracts authorized under this subsection.

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

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

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

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

Sec. 403. From the funds appropriated in part 1 for multicultural services, the department shall ensure that CMHSPs continue contracts with multicultural services providers.

Sec. 404. (1) Not later than May 31 of each fiscal year, the department shall provide a report on the community mental health services programs to the members of the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director that includes the information required by this section.

(2) The report shall contain information for each CMHSP and a statewide summary, each of which shall include at least the following information:

(a) A demographic description of service recipients which, minimally, shall include reimbursement eligibility, client population, age, ethnicity, housing arrangements, and diagnosis.

(b) When the encounter data is available, a breakdown of clients served, by diagnosis. As used in this subdivision, "diagnosis" means a recipient's primary diagnosis, stated as a specifically named mental illness, emotional disorder, or developmental disability corresponding to terminology employed in the latest edition of the American psychiatric association's diagnostic and statistical manual.

(c) Per capita expenditures by client population group.

(d) Financial information which, minimally, shall include a description of funding authorized; expenditures by client group and fund source; and cost information by service category, including administration. Service category shall include all department approved services.

(e) Data describing service outcomes which shall include, but not be limited to, an evaluation of consumer satisfaction, consumer choice, and quality of life concerns including, but not limited to, housing and employment.

(f) Information about access to community mental health services programs which shall include, but not be limited to, the following:

(i) The number of people receiving requested services.

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

(iii) The number of people requesting services who are on waiting lists for services.

(iv) The average length of time that people remained on waiting lists for services.

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

(h) An analysis of information provided by community mental health service programs in response to the needs assessment requirements of the mental health code, including information about the number of persons in the service delivery system who have requested and are clinically appropriate for different services.

(i) An estimate of the number of FTEs employed by the CMHSPs or contracted with directly by the CMHSPs as of September 30, 2001 and an estimate of the number of FTEs employed through contracts with provider organizations as of September 30, 2001.

(j) Lapses and carryforwards during fiscal year 2000-2001 for CMHSPs.

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

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

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

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

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

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

Sec. 405. It is the intent of the legislature that the employee wage pass-through funded to the community mental health services programs for direct care workers in local residential settings and for paraprofessional and other nonprofessional direct care workers in day programs, supported employment, and other vocational programs shall continue to be paid to direct care workers.

Sec. 406. (1) The funds appropriated in part 1 for the state disability assistance substance abuse services program shall be used to support per diem room and board payments in substance abuse residential facilities. Eligibility of clients for the state disability assistance substance abuse services program shall include needy persons 18 years of age or older, or emancipated minors, who reside in a substance abuse treatment center.

(2) The department shall reimburse all licensed substance abuse programs eligible to participate in the program at a rate equivalent to that paid by the family independence agency to adult foster care providers. Programs accredited by department-approved accrediting organizations shall be reimbursed at the personal care rate, while all other eligible programs shall be reimbursed at the domiciliary care rate.

Sec. 407. (1) The amount appropriated in part 1 for substance abuse prevention, education, and treatment grants shall be expended for contracting with coordinating agencies or designated service providers. It is the intent of the legislature that the coordinating agencies and designated service providers work with the CMHSPs to coordinate the care and services provided to individuals with both mental illness and substance abuse diagnoses.

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

Sec. 408. (1) By April 15, 2002, the department shall report the following data from fiscal year 2000-2001 on substance abuse prevention, education, and treatment programs to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget office:

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

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

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

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

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

Sec. 409. The funding in part 1 for substance abuse services shall be distributed in a manner that provides priority to service providers that furnish child care services to clients with children.

Sec. 410. The department shall assure that substance abuse treatment is provided to applicants and recipients of public assistance through the family independence agency who are required to obtain substance abuse treatment as a condition of eligibility for public assistance.

Sec. 411. (1) The department shall ensure that each contract with a CMHSP requires the CMHSP to implement programs to encourage diversion of persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.

(2) Each CMHSP shall have jail diversion services and shall work toward establishing working relationships with representative staff of local law enforcement agencies, including county prosecutors' offices, county sheriffs' offices, county jails, municipal police agencies, municipal detention facilities, and the courts. Written interagency agreements describing what services each participating agency is prepared to commit to the local jail diversion effort and the procedures to be used by local law enforcement agencies to access mental health jail diversion services are strongly encouraged.

Sec. 412. The department shall contract directly with the Salvation Army harbor light program and Salvation Army turning point of west Michigan to provide non-Medicaid substance abuse services.

Sec. 413. No later than October 10, 2001, the department shall report to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the methodology utilized and the adjustments made in recalculating the capitation rates payable to CMHSPs and other managing entities under the federal waiver for Michigan managed specialty services and supports program.

Sec. 414. Medicaid substance abuse treatment services shall be managed by selected CMHSPs pursuant to the health care financing administration's approval of Michigan's 1915(b) waiver request to implement a managed care plan for specialized substance abuse services. The selected CMHSPs shall receive a capitated payment on a per eligible per month basis to assure provision of medically necessary substance abuse services to all beneficiaries who require those services. The selected CMHSPs shall be responsible for the reimbursement of claims for specialized substance abuse services. The CMHSPs that are not coordinating agencies may continue to contract with a coordinating agency. Any alternative arrangement must be based on client service needs and have prior approval from the department.

Sec. 416. (1) Of the funds appropriated in part 1 for pharmaceutical services, community mental health boards shall not be held liable for the cost of prescribed psychotropic medications during fiscal year 2001-2002.

(2) In calculating the available amount of lapses for use in offsetting overexpenditures resulting from the implementation of this section, those lapses credited to community mental health line items shall only include appropriation lapses in excess of the amount calculated for the 5% carryforward defined in state statute.

(3) The department shall provide quarterly reports to the senate and house of representatives appropriations subcommittees on community health, their respective fiscal agencies, and community mental health boards that include data on psychotropic medications regarding the type, number, cost and prescribing patterns of Medicaid providers.

(4) Should expenditures for Medicaid mental health services and Medicaid substance abuse services exceed the appropriations contemplated in part 1 due to an increase in the number or mix of Medicaid eligibles, the department shall request the transfer of appropriation lapses or supplemental funding as may be necessary to offset such expenditures.

Sec. 417. (1) It is the intent of the legislature that the department support pilot projects by community mental health boards to establish regional partnerships. Community mental health boards located in counties within a 45-mile radius of each other shall be allowed to collaborate for the purpose of forming regional partnerships.

(2) The purpose of the regional partnerships should be to expand consumer choice, promote service integration, and produce system efficiencies through the coordination of efforts, or other outcomes, as may be determined by participating community mental health boards.

(3) The pilot projects described in this section shall be completely voluntary and be based on projects proposed by the community mental health boards. Each proposed pilot project shall be consistent with the scope, duration, risks, and inducements contained in the plan for competitive procurement that the department submits to the health care financing administration as part of the renewal request for the section 1915(b) managed specialty services waiver.

(4) As an additional incentive for community mental health boards to engage in the pilot projects described in this section, the department shall allow any regional partnership formed under this section to retain 100% of any net lapses generated by the regional partnership.

(5) The department shall provide quarterly reports to the senate and house of representatives appropriations subcommittees and their respective fiscal agencies and the state budget office, as to any activities by community mental health boards to form regional partnerships under this section.

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

Sec. 419. From the funds appropriated in part 1 for Medicaid substance abuse services and community substance abuse prevention, education, and treatment programs, the department and a CMHSP that contract with a substance abuse coordinating agency shall include a provision in the contract that allows the agency to carry forward up to 5% of its revenue.

Sec. 421. Of the TANF funds appropriated in part 1 for community substance abuse prevention, education, and treatment programs, \$700,000.00 shall be allocated to provide treatment services for substance abusing nonviolent offenders identified by the drug courts administered by the state court administrative office as described in section 322 of 2000 PA 264 and \$300,000.00 shall be allocated to the Phoenix house program.

Sec. 422. (1) It is the intent of the legislature that the department support pilot projects by CMHSPs to control and manage psychotropic drug costs associated with the managed specialty services and supports program.

(2) The purpose of the pilot projects is to allow CMHSPs to develop the necessary management and financial tools to assume risk for the responsibility of managing psychotropic drug costs.

(3) The pilot projects described in this section shall be completely voluntary and based on projects proposed by the CMHSPs.

(4) The department shall provide quarterly reports to the house of representatives and senate appropriations subcommittees on community health, the state budget office, and the house and senate fiscal agencies as to any activities by CMHSPs to pilot projects under this section.

Sec. 423. The department shall work cooperatively with the family independence agency and the departments of corrections, education, state police, and military and veterans affairs to coordinate and improve the delivery of substance abuse prevention, education, and treatment programs within existing appropriations. The department shall report by March 15, 2002 on the outcomes of this cooperative effort to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director.

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

(a) A "clean claim" as described in 2000 PA 187 must be paid within 45 days after receipt of the claim by the community mental health services program. A clean claim that is not paid within this time frame shall bear simple interest at a rate of 12% per annum.

(b) A community mental health services program must state in writing to the health professional or facility any defect in the claim within 30 days after receipt of the claim.

(c) A health professional and a health facility have 30 days after receipt of a notice that a claim or a portion of a claim is defective within which to correct the defect. The community mental health services program shall pay the claim within 30 days after the defect is corrected.

Sec. 425. By March 1, 2002, the department, in conjunction with the department of corrections, shall report the following data from fiscal year 2000-2001 on mental health and substance abuse services to the house of representatives and senate appropriations subcommittees on community health and corrections, the house and senate fiscal agencies, and the state budget office:

(a) The number of prisoners receiving substance abuse services which shall include a description and breakdown on the type of substance abuse services provided to prisoners.

(b) The number of prisoners receiving mental health services which shall include a description and breakdown on the type of mental health services provided to prisoners.

(c) Data indicating if prisoners receiving mental health services were previously hospitalized in a state psychiatric hospital for persons with mental illness.

Sec. 426. (1) By May 31, 2002, the department shall provide the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director with a report on mental health services to minors assigned or referred by the courts and found to meet CMHSP clinical and financial eligibility determination requirements for fiscal year 2000-2001.

(2) The report described in subsection (1) shall contain information for each CMHSP calculated by the department from fiscal year 2000-2001 data reporting requirements and a statewide summary, each of which shall contain at least the following information:

(a) The number of minors meeting the criteria in subsection (1) and evaluated as a result of court assignment or referral.

(b) The number of minors meeting the criteria in subsection (1) and receiving treatment after the court assignment or referral.

(c) A breakdown of minors meeting the criteria in subsection (1) receiving treatment, by the following categories:

(i) Age.

(ii) Primary diagnosis, stated as a specifically named condition corresponding to the terminology employed in the latest version of the diagnostic and statistical manual of the American psychiatric association.

(iii) Whether or not the score on the state designated outcome instrument indicated marked or severe functional impairment.

(iv) Average length of stay in CMHSP treatment.

- (v) Unduplicated count of the number receiving residential service and average length of stay in residential service.
- (vi) Number of recipients served under each categorical children's service heading maintained by the department for standard reporting purposes.

Sec. 427. (1) Unless required by federal law, the department shall not enact any contract changes concerning capitation payments to CMHSPs for Medicaid eligibles unless agreed to by contract with CMHSPs.

(2) In the event that the federal government mandates that the department make any changes in eligibility or payment rates for CMHSP Medicaid capitation payments, the department shall inform the members of the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director within 2 weeks of the estimated change in CMH Medicaid expenditures due to the federally mandated policy change.

(3) The department may not alter CMH Medicaid capitation rates in order to offset any increases in costs due to increases in Medicaid caseload or case mixture.

(4) Before submitting any state plan amendment to the federal waiver for the managed specialty services and supports program to the federal health care financing administration or its successor, the department shall submit a copy of the amendment to the legislature.

Sec. 428. (1) Subject to the conditions specified in subsection (4), a CMHSP, under contract with the department to provide comprehensive community mental health services, that was constituted as an authority, regional partnership, or other similar entity approved by the department, as of June 1, 2001, shall be eligible to receive an increase in their Medicaid capitation rates of up to 5.3% effective October 1, 2001.

(2) Subject to the conditions specified in subsection (4), a CMHSP under contract with the department to provide comprehensive community mental health services that reconstitutes as an authority, regional partnership, or other similar entity approved by the department, after June 1, 2001 but before October 1, 2001, shall be eligible to receive an increase in their Medicaid capitation rates of up to 4.4% effective October 1, 2001.

(3) Effective October 1, 2001 and subject to the conditions specified in subsection (4), a CMHSP under contract with the department to provide comprehensive community mental health services that fails to become an authority, regional partnership, or other similar entity approved by the department, shall have their capitation rates reduced by 2%. Should the entity subsequently become an authority, regional partnership, or other similar entity approved by the department, that entity shall have its capitation rates restored and may receive a capitation rate increase of up to 1.8% as of the effective date that the entity obtains its authority, regional partnership, or other similar entity approved by the department status.

(4) The ability of an authority, regional partnership, or other similar entity approved by the department to receive a capitation rate increase as specified in subsection (1), (2), or (3) is predicated on the capacity of that entity to provide, from internal resources, funds that can be used as a bona fide source for the state match required under the Medicaid program. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a CMHSP.

(5) No later than October 15, 2001, the department shall submit a state plan amendment to effectuate the requirements of this section and shall immediately implement the requirements of this section upon receipt of approval of the state plan amendment by the federal health care financing administration or its successor.

Sec. 430. From the funds appropriated in part 1 for community mental health non-Medicaid services, CMHSPs that contract with local providers of mental health services and services for persons with developmental disabilities, under a capitated reimbursement system, may include a provision in the contract that allows the providers to carry forward up to 5% of unobligated capitation payments.

Sec. 431. From the funds appropriated in part 1 for Medicaid mental health services, CMHSPs that contract with local providers of mental health services and services for persons with developmental disabilities, under a capitated reimbursement system, may include a provision in the contract that allows the providers to carry forward up to 5% of unobligated capitation payments.

Sec. 432. It is the intent of the legislature that all community mental health services programs establish regular ongoing discussions with local providers of mental health services, substance abuse services, and services to persons with developmental disabilities in preparation for competitive procurement of these services as described in the plan approved by the health care financing administration. These discussions shall include representatives of the county or counties included in the service area of the community mental health services program and should take into account maintaining continuity of care for patients and service recipients in the transition to competitive procurement of services.

Sec. 433. The department shall apply for a "system of change" grant from the health care financing administration. This grant is intended to support self-determination initiatives, including a consumer cooperative proposal, for persons with developmental disabilities and persons with mental illness.

Sec. 435. A county required under the provisions of the mental health code, 1974 PA 258, MCL 330.1110 to 330.2106, to provide matching funds to a CMHSP for mental health services rendered to residents in its jurisdiction shall pay the matching funds in equal installments on not less than a quarterly basis throughout the fiscal year, with the first payment being made by October 1, 2001.

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

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

(2) The department shall continue a revenue recapture project to generate additional revenues from third parties related to cases that have been closed or are inactive. Revenues collected through project efforts are appropriated to the department for departmental costs and contractual fees associated with these retroactive collections and to improve ongoing departmental reimbursement management functions so that the need for retroactive collections will be reduced or eliminated.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to \$2,000,000.00 remaining on September 30, 2002 from pay telephone revenues and the amounts appropriated in part 1 for gifts and bequests for patient living and treatment environments shall be carried forward for 1 fiscal year. The purpose of gifts and bequests for patient living and treatment environments is to use additional private funds to provide specific enhancements for individuals residing at state-operated facilities. Use of the gifts and bequests shall be consistent with the stipulation of the donor. The expected completion date for the use of gifts and bequests donations is within 3 years unless otherwise stipulated by the donor.

Sec. 603. The funds appropriated in part 1 for forensic mental health services provided to the department of corrections are in accordance with the interdepartmental plan developed in cooperation with the department of corrections. The department is authorized to receive and expend funds from the department of corrections in addition to the appropriations in part 1 to fulfill the obligations outlined in the interdepartmental agreements.

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

- (a) The number of days of care purchased from state hospitals and centers.
- (b) The number of days of care purchased from private hospitals in lieu of purchasing days of care from state hospitals and centers.
- (c) The number and type of alternative placements to state hospitals and centers other than private hospitals.
- (d) Waiting lists for placements in state hospitals and centers.

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

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

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

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

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

PUBLIC HEALTH ADMINISTRATION

Sec. 703. The availability of \$200,000.00 for vital records and health systems is contingent upon the enactment of legislation that amends section 2891 of the public health code, 1978 PA 368, MCL 333.2891, to increase fees for vital records services in an amount sufficient to produce \$200,000.00 in fee revenue anticipated to be received annually, and that fee increase taking effect.

INFECTIOUS DISEASE CONTROL

Sec. 801. In the expenditure of funds appropriated in part 1 for AIDS programs, the department and its subcontractors shall ensure that adolescents receive priority for prevention, education, and outreach services.

Sec. 802. In developing and implementing AIDS provider education activities, the department may provide funding to the Michigan state medical society to serve as lead agency to convene a consortium of health care providers, to design needed educational efforts, to fund other statewide provider groups, and to assure implementation of these efforts, in accordance with a plan approved by the department.

Sec. 803. The department shall continue the AIDS drug assistance program maintaining the prior year eligibility criteria and drug formulary. This section is not intended to prohibit the department from providing assistance for improved AIDS treatment medications.

Sec. 804. From the funds appropriated in part 1 for AIDS prevention, testing, and care programs, \$100.00 shall be available only if additional funding becomes available from the centers for disease control.

LABORATORY SERVICES

Sec. 840. From the funds appropriated in part 1 for laboratory services, \$100.00 shall be made available for Hepatitis C testing and counseling only if federal funds become available from the centers for disease control.

EPIDEMIOLOGY

Sec. 851. From the funds appropriated in part 1 for epidemiology administration, \$300,000.00 shall be allocated for an asthma intervention program, including surveillance, community-based programs, and awareness and education. The department shall seek federal funds as they are made available for asthma programs.

LOCAL HEALTH ADMINISTRATION AND GRANTS

Sec. 901. The amount appropriated in part 1 for implementation of the 1993 amendments to sections 9161, 16221, 16226, 17014, 17015, and 17515 of the public health code, 1978 PA 368, MCL 333.9161, 333.16221, 333.16226, 333.17014, 333.17015, and 333.17515, shall reimburse local health departments for costs incurred related to implementation of section 17015(15) of the public health code, 1978 PA 368, MCL 333.17015.

Sec. 902. If a county that has participated in a district health department or an associated arrangement with other local health departments takes action to cease to participate in such an arrangement after October 1, 2001, the department shall have the authority to assess a penalty from the local health department's operational accounts in an amount equal to no more than 5% of the local health department's local public health operations funding. This penalty shall only be assessed to the local county that requests the dissolution of the health department.

Sec. 903. The department shall provide a report semiannually to the house of representatives and senate appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the expenditures and activities undertaken by the lead abatement program. The report shall include, but is not limited to, a funding allocation schedule, expenditures by category of expenditure and by subcontractor, revenues received, description of program elements, and description of program accomplishments and progress.

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

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

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

(3) Distributions in subsection (1) shall be made only to counties that maintain local spending in fiscal year 2001-2002 of at least the amount expended in fiscal year 1992-1993 for the services described in subsection (1).

(4) By April 1, 2002, the department shall make available upon request a report to the senate or house of representatives appropriations subcommittee on community health, the senate or house fiscal agency, or the state budget director on the planned allocation of the funds appropriated for local public health operations.

Sec. 906. From the funds appropriated in part 1 for local health services, the department shall allocate \$50,000.00 for the continuation of a study to identify the sources of pollution and those responsible for polluting in the Clinton river watershed, and, upon completion of the pollution study, for a hydrology analysis of the Clinton river watershed.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

Sec. 1001. From the state funds appropriated in part 1, the department shall allocate funds to promote awareness, education, and early detection of breast, cervical, prostate, and colorectal cancer, and provide for other health promotion media activities. The department shall allocate no less than \$150,000.00 under this section for colorectal cancer awareness, education, and early detection.

Sec. 1002. (1) The amount appropriated in part 1 for school health and education programs shall be allocated in fiscal year 2001-2002 to provide grants to or contract with certain districts and intermediate districts for the provision of a school health education curriculum. Provision of the curriculum, such as the Michigan model or another comprehensive school health education curriculum, shall be in accordance with the health education goals established by the Michigan model for the comprehensive school health education state steering committee. The state steering committee shall be comprised of a representative from each of the following offices and departments:

- (a) The department of education.
- (b) The department of community health.
- (c) The public health agency in the department of community health.
- (d) The office of substance abuse services in the department of community health.
- (e) The family independence agency.
- (f) The department of state police.

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

Sec. 1003. Funds appropriated in part 1 for the Alzheimer's information network shall be used to provide information and referral services through regional networks for persons with Alzheimer's disease or related disorders, their families, and health care providers.

Sec. 1005. From the funds appropriated in part 1 for physical fitness, nutrition, and health, up to \$1,000,000.00 may be allocated to the Michigan physical fitness and sports foundation. The allocation to the Michigan physical fitness and sports foundation is one-time funding and is contingent upon the foundation providing at least a 20% cash match.

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

Sec. 1007. (1) The funds appropriated in part 1 for violence prevention shall be used for, but not be limited to, the following:

- (a) Programs aimed at the prevention of spouse, partner, or child abuse and rape.
- (b) Programs aimed at the prevention of workplace violence.

(2) In awarding grants from the amounts appropriated in part 1 for violence prevention, the department shall give equal consideration to public and private nonprofit applicants.

(3) From the funds appropriated in part 1 for violence prevention, the department may include local school districts as recipients of the funds for family violence prevention programs.

Sec. 1008. From the amount appropriated in part 1 for the cancer prevention and control program, \$3,000,000.00 shall be allocated to the Karmanos Cancer Institute/Wayne State University, to the University of Michigan comprehensive cancer center, and to Michigan State University for cancer and cancer prevention services and activities, consistent with the current priorities of the Michigan cancer consortium.

Sec. 1009. From the funds appropriated in part 1 for the diabetes and kidney program, a portion of the funds may be allocated to the National Kidney Foundation of Michigan for kidney disease prevention programming including early identification and education programs and kidney disease prevention demonstration projects.

Sec. 1010. Of the funds appropriated in part 1 for the health education, promotion, and research programs, the department shall allocate not less than \$400,000.00 to implement the osteoporosis prevention and treatment education program targeting women and school health education. As part of the program, the department shall design and implement strategies for raising public awareness on the causes and nature of osteoporosis, personal risk factors, value of prevention and early detection, and options for diagnosing and treating osteoporosis.

Sec. 1011. (1) From the funds appropriated in part 1 for the diabetes and kidney program, \$420,000.00 shall be allocated for improving the health of African-American men in Michigan. The funds shall be used for screening and patient self-care activities for diabetes, hypertension, stroke, and glaucoma and other eye diseases.

(2) By March 1, 2002, the department shall make available upon request a report on the program under this section to the senate or house of representatives appropriations subcommittee on community health, the senate or house fiscal agency, or the state budget director.

Sec. 1013. The funds appropriated in part 1 for the Michigan Parkinson's Foundation shall be used for implementation of the Michigan Parkinson's Initiative which supports and educates persons with Parkinson's disease and their families. Members of the Michigan Parkinson's Initiative include the University of Michigan, Michigan State University, Wayne State University, Beaumont Hospital, St. John's Hospital and Health Center, Henry Ford Health System, and other organizations as appropriate.

Sec. 1019. From the funds appropriated in part 1 for chronic disease prevention, \$50,000.00 shall be allocated for stroke prevention, education, and outreach. The objectives of the program shall include education to assist persons in identifying risk factors, and education to assist persons in the early identification of the occurrence of a stroke in order to minimize stroke damage.

Sec. 1020. From the funds appropriated in part 1 for chronic disease prevention, \$100,000.00 shall be allocated for a childhood and adult arthritis program.

Sec. 1021. From the funds appropriated in part 1 for health education, promotion, and research programs, \$100,000.00 shall be granted to the greater Detroit area health council's African-American health institute for the African-American health conference.

Sec. 1022. From the funds appropriated in part 1 for the smoking prevention program, \$1,500,000.00 shall be allocated as 1-time funding to enable eligible state and local municipalities to apply for American legacy foundation grants which are intended to decrease and prevent tobacco consumption among all ages and populations.

Sec. 1023. From the funds appropriated in part 1 for physical fitness, nutrition, and health, up to \$125,000.00 may be allocated for wellness programs of the Michigan Athletic Institute.

COMMUNITY LIVING, CHILDREN, AND FAMILIES

Sec. 1101. The department shall review the basis for the distribution of funds to local health departments and other public and private agencies for the women, infants, and children food supplement program; family planning; early and periodic screening, diagnosis, and treatment program; and prenatal care outreach and service delivery support program and indicate the basis upon which any projected underexpenditures by local public and private agencies shall be reallocated to other local agencies that demonstrate need.

Sec. 1102. (1) Agencies receiving funds for adolescent health care services that are appropriated from part 1 for adolescent and child health care services shall do all of the following:

(a) Require each adolescent health clinic funded by the agency to report to the department on an annual basis all of the following information:

(i) Funding sources of the adolescent health clinic.

(ii) Demographic information of populations served including sex, age, and race. Reporting and presentation of demographic data by age shall include the range of ages of 0-17 years and the range of ages of 18-23 years.

(iii) Utilization data that reflects the number of visits and repeat visits and types of services provided per visit.

(iv) Types and number of referrals to other health care agencies.

(b) As a condition of the contract, a contract shall include the establishment of a local advisory committee before the planning phase of an adolescent health clinic intended to provide services within that school district. The advisory committee shall be comprised of not less than 50% residents of the local school district, and shall not be comprised of more than 50% health care providers. A person who is employed by the sponsoring agency shall not have voting privileges as a member of the advisory committee.

(c) Not allow an adolescent health clinic funded by the agency, as part of the services offered, to provide abortion counseling or services or make referrals for abortion services.

(d) Require each adolescent health clinic funded by the agency to have a written policy on parental consent, developed by the local advisory committee and submitted to the local school board for approval if the services are provided in a public school building where instruction is provided in grades kindergarten through 12.

(2) A local advisory committee established under subsection (1)(b), in cooperation with the sponsoring agency, shall submit written recommendations regarding the implementation and types of services rendered by an adolescent health clinic to the local school board for approval of adolescent health services rendered in a public school building where instruction is provided in grades kindergarten through 12.

(3) The department shall submit a report to the members of the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director based on the information provided under subsection (1)(a). The report is due 90 days after the end of the calendar year.

Sec. 1103. Of the funds allocated for adolescent health care services that are appropriated in part 1 for adolescent and child health care services, each teen center, including alternative models, shall receive funding based upon a formula that includes a base amount equal to the amount received by each center in fiscal year 2000-2001, with the remaining funds allocated for teen health centers to be distributed based upon the number of users, visits, and services provided.

Sec. 1104. Before April 1, 2002, the department shall submit a report to the house and senate fiscal agencies and the state budget director on planned allocations from the amounts appropriated in part 1 for local MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs. Using applicable federal definitions, the report shall include information on all of the following:

(a) Funding allocations.

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

(c) Actual numbers served and amounts expended in the categories described in subdivisions (a) and (b) for the fiscal year 2000-2001.

Sec. 1105. For all programs for which an appropriation is made in part 1, the department shall contract with those local agencies best able to serve clients. Factors to be used by the department in evaluating agencies under this section shall include ability to serve high-risk population groups; ability to serve low-income clients, where applicable; availability of, and access to, service sites; management efficiency; and ability to meet federal standards, when applicable.

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

Sec. 1106a. (1) Federal abstinence money expended in part 1 for the purpose of promoting abstinence education shall provide abstinence education to teenagers most likely to engage in high-risk behavior as their primary focus, and may include programs that include 9- to 17-year-olds. Programs funded must meet all of the following guidelines:

(a) Teaches the gains to be realized by abstaining from sexual activity.

(b) Teaches abstinence from sexual activity outside of marriage as the expected standard for all school age children.

(c) Teaches that abstinence is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other health problems.

(d) Teaches that a monogamous relationship in the context of marriage is the expected standard of human sexual activity.

(e) Teaches that sexual activity outside of marriage is likely to have harmful effects.

(f) Teaches that bearing children out of wedlock is likely to have harmful consequences.

(g) Teaches young people how to avoid sexual advances and how alcohol and drug use increases vulnerability to sexual advances.

(h) Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

(2) Coalitions, organizations, and programs that do not provide contraceptives to minors and demonstrate efforts to include parental involvement as a means of reducing the risk of teens becoming pregnant shall be given priority in the allocations of funds.

(3) Programs and organizations that meet the guidelines of subsection (1) and criteria of subsection (2) shall have the option of receiving all or part of their funds directly from the department of community health.

Sec. 1107. Of the amount appropriated in part 1 for prenatal care outreach and service delivery support, not more than 10% shall be expended for local administration, data processing, and evaluation.

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

Sec. 1109. (1) From the amounts appropriated in part 1 for dental programs, funds shall be allocated to the Michigan dental association for the administration of a volunteer dental program that would provide dental services to the uninsured in an amount that is no less than the amount allocated to that program in fiscal year 1996-1997.

(2) Not later than November 1, 2001, the department shall make available upon request a report to the senate or house of representatives appropriations subcommittee on community health or the senate or house of representatives standing committee on health policy the number of individual patients treated, number of procedures performed, and approximate total market value of those procedures through September 30, 2001.

Sec. 1110. Agencies that currently receive pregnancy prevention funds and either receive or are eligible for other family planning funds shall have the option of receiving all of their family planning funds directly from the department of community health and be designated as delegate agencies.

Sec. 1111. The department shall allocate no less than 87% of the funds appropriated in part 1 for family planning local agreements and the pregnancy prevention program for the direct provision of family planning/pregnancy prevention services.

Sec. 1112. From the funds appropriated for prenatal care outreach and service delivery support, the department shall allocate at least \$1,000,000.00 to communities with high infant mortality rates.

Sec. 1113. From the funds appropriated in part 1 for special projects, the department shall allocate no less than \$200,000.00 to provide education and outreach to targeted populations on the dangers of drug use during pregnancy, neonatal addiction, and fetal alcohol syndrome and further develop its infant support services to target families with infants with fetal alcohol syndrome or suffering from drug addiction.

Sec. 1115. From the funds appropriated in part 1 for special projects, the department shall allocate \$200,000.00 for pilot grants to institutions of higher education to make available a network of resources and support services for students enrolled in the participating institution of higher education who are in need of pregnancy and parenting services. The funds shall also be utilized for administration of the grants and assessment of need. This appropriation shall be established as a 3-year work project. For purposes of this section, "institution of higher education" means a university, college, or community college located in the state of Michigan.

Sec. 1116. The department shall give priority in the awarding of contracts for the funds appropriated in part 1 for the pregnancy prevention program to organizations that provide pregnancy prevention services as their primary function and to local health departments.

Sec. 1120. The department shall allocate \$8,488,600.00 to local public health departments for the purpose of providing EPSDT, maternal and infant support services outreach, and other Medicaid outreach and support services.

Sec. 1121. From the funds appropriated in part 1 for special projects, \$249,900.00 shall be allocated for the continuation of children's respite services that were funded in fiscal year 2000-2001.

Sec. 1122. The department shall convene an infant mortality summit to focus on the reduction of the disparities in the minority and nonminority infant mortality rates in Michigan, as well as the disparities in the rate between Michigan communities. The summit shall focus on local and national practices that have proven to be effective at accomplishing these reductions. The summit shall also advise the department in prioritizing its efforts in reviewing its Medicaid, public health, and related programs to determine how to improve these systems and cooperation among the organizations, both state and local, to make them more effective. The summit shall consist of 2 members of the house of representatives, 2 members of the senate, and at least 1 representative from each of the following organizations: the Michigan council for maternal and child health, Michigan state medical society, Michigan nurses association, march of dimes, Michigan State University, Michigan SIDS alliance, Michigan association for local public health, Michigan association of health plans, and Michigan health and hospital association. Senate members shall be appointed by the senate majority leader. House members shall be appointed by the speaker of the house of representatives. There shall be equal representation of republican and democratic legislative members of the summit. The department shall report the summit findings to the house and senate appropriations committees no later than March 1, 2002.

Sec. 1123. The department shall require that a community application or applicant for new funding, over which the department has control, for birth to age 5 programs, seek agreement with the comprehensive community plan created to meet the application requirements of section 32b of the state school aid act of 1979, 1979 PA 94, MCL 388.1632b.

Sec. 1124. (1) From the funds appropriated in part 1 from the federal maternal and child health block grant, \$450,000.00 shall be allocated if additional block grant funds are available for the statewide fetal infant mortality review network.

(2) It is the intent of the legislature that this project shall be funded with a like amount in fiscal year 2002-2003 should federal funds become available.

Sec. 1125. Of the funds appropriated in part 1 for adolescent and child health care services, the department shall allocate up to \$1,500,000.00 for an elementary school-based primary health care program. Participating organizations are required to provide a 67% funding match. Participating organizations may bill state or federal insurance programs or private or commercial health insurance programs for services provided. A standardized quality assurance system shall be established by the department for participating organizations. A participating organization shall be eligible to receive a \$25.00 outreach payment through the local health department from the Medicaid outreach program for each person assisted in completing the application process for MICHild or Medicaid.

Sec. 1126. In implementing the early childhood collaborative secondary prevention program, the department shall work cooperatively with the department of education and the family independence agency to address issues and coordinate activities for community-based collaborative prevention services. The department shall report annually on the outcomes of this collaborative effort to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies.

Sec. 1127. The department shall make a 1-time allocation of \$200,000.00 to the Bay County library system for the purpose of expanding services and accommodations for disabled children and adults.

Sec. 1128. The department shall make every effort to maximize the receipt of federal Medicaid funds to support the activities of the migrant health care line item.

WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Sec. 1150. In administering the federal summer food service program for children, the department shall work to effectively utilize when possible resources and infrastructure that are in place for existing food programs administered by the department and other state agencies including the department of education.

Sec. 1151. The department may work with local participating agencies to define local annual contributions for the farmer's market nutrition program, project FRESH, to enable the department to request federal matching funds by April 1, 2002 based on local commitment of funds.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

Sec. 1201. Funds appropriated in part 1 for medical care and treatment of children with special health care needs shall be paid according to reimbursement policies determined by the Michigan medical services program. Exceptions to these policies may be taken with the prior approval of the state budget director.

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

- (a) Provide special formula for eligible clients with specified metabolic and allergic disorders.
- (b) Provide medical care and treatment to eligible patients with cystic fibrosis who are 21 years of age or older.
- (c) Provide genetic diagnostic and counseling services for eligible families.
- (d) Provide medical care and treatment to eligible patients with hereditary coagulation defects, commonly known as hemophilia, who are 21 years of age or older.

Sec. 1203. All children who are determined medically eligible for the children's special health care services program shall be referred to the appropriate locally-based services program in their community.

CRIME VICTIM SERVICES COMMISSION

Sec. 1301. The per diem amount authorized for the crime victim services commission is \$100.00.

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

Sec. 1303. (1) From the funds appropriated in part 1 for crime victim rights services grants, victims of criminal sexual assault shall be eligible to obtain reimbursement for the costs of any medically necessary services that may be needed for the collection of evidence used to identify, apprehend, and prosecute the offender or offenders, and that would otherwise be the financial responsibility of the victim.

(2) This section shall apply only if authorized at any time during fiscal year 2001-2002 by 1976 PA 223, MCL 18.351 to 18.368.

OFFICE OF SERVICES TO THE AGING

Sec. 1401. The appropriation in part 1 to the office of services to the aging, for community and nutrition services and home services, shall be restricted to eligible individuals at least 60 years of age who fail to qualify for home care services under title XVIII, XIX, or XX of the social security act, chapter 531, 49 Stat. 620.

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

- (a) The recipient's degree of frailty.
- (b) The recipient's inability to prepare his or her own meals safely.
- (c) Whether the recipient has another care provider available.
- (d) Any other qualifications normally necessary for the recipient to receive home delivered meals.

Sec. 1404. The office of services to the aging may receive and expend fees for the provision of day care, care management, and respite care. The office of services to the aging shall base the fees on a sliding scale taking into consideration the client income. The office of services to the aging shall use the fees to expand services.

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

Sec. 1406. The appropriation of \$5,000,000.00 of tobacco settlement funds to the office of services to the aging for the respite care program shall be allocated in accordance with a long-term care plan developed by the long-term care working group established in section 1657 of 1998 PA 336 upon implementation of the plan. The plan shall be implemented upon meeting the requirements of section 1684 of this act. The use of the funds shall be for direct respite care or adult respite care center services. Not more than 10% of the amount allocated under this section shall be expended for administration and administrative purposes.

Sec. 1407. (1) The appropriation of \$3,046,000.00 of tobacco settlement funds to the office of services to the aging for the long-term care advisor shall be allocated in accordance with a long-term care plan developed by the long-term care working group established in section 1657 of 1998 PA 336 upon implementation of the plan. The plan shall be implemented upon meeting the requirements of section 1684 of this act.

(2) Activities of the long-term care advisor shall support awareness for a continuum of care for older adults including assisted living arrangements, and shall promote and support family involvement.

Sec. 1408. The office of services to the aging shall provide that funds appropriated under this act shall be awarded on a local level in accordance with locally determined needs.

Sec. 1413. The legislature affirms the commitment to locally-based services. The legislature supports the role of local county board of commissioners in the approval of area agency on aging plans. The legislature supports choice and the right of local counties to change membership in the area agencies on aging if the change is to an area agency on aging that is contiguous to that county. The legislature supports the office of services to the aging working with others to provide training to commissions to better understand and advocate for aging issues. It is the intent of the legislature to prohibit area agencies on aging from providing direct services, including home and community-based waiver services, unless they receive a waiver from the department. The legislature's intent in this section is conditioned on compliance with federal and state laws, rules, and policies.

Sec. 1416. The legislature affirms the commitment to provide in-home services, resources, and assistance for the frail elderly who are not being served by the Medicaid home and community services waiver program.

MEDICAL SERVICES ADMINISTRATION

Sec. 1501. The funds appropriated in part 1 for the Michigan essential health care provider program may also provide loan repayment for dentists that fit the criteria established by part 27 of the public health code, 1978 PA 368, MCL 333.2701 to 333.2727.

Sec. 1502. The department is directed to continue support of multicultural agencies that provide primary care services from the funds appropriated in part 1.

Sec. 1503. From the amounts appropriated in part 1 for palliative and end of life care, \$316,200.00 shall be allocated for education programs on and promotion of palliative care, hospice, and end of life care. The department shall provide a report on the interim results of the hospice pilot project to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies by April 1, 2002.

Sec. 1504. From the funds appropriated in part 1 for primary care services, the department shall appropriate at least the same level of financing for the Arab American and Chaldean council, and ACCESS that was appropriated in fiscal year 1999-2000.

Sec. 1505. The department shall work with the department of career development to explore options available under the federal "Ticket to Work and Work Incentives Improvement Act of 1999". The department shall provide a report on the options to extend health care coverage for working disabled persons under federal law by October 1, 2001.

Sec. 1506. From the funds appropriated in part 1 for primary care services, an amount not to exceed \$4,000,000.00 is appropriated to enhance the service capacity of the federally qualified health centers and other health centers which are similar to federally qualified health centers.

Sec. 1507. From the funds appropriated in part 1 for primary care services, \$100,000.00 may be allocated to free health clinics operating in the state. An advisory committee may be appointed by the department and include not less than 4 members representing free health clinics, 1 member representing the Michigan state medical society, 1 member representing the Michigan health and hospital association, and 1 member representing nurse practitioners. Health clinics receiving funding under this section shall register with the department by submitting a form to be designed by the committee. For the purpose of this appropriation, free health clinics are health care facilities that provide services without charge or compensation.

MEDICAL SERVICES

Sec. 1601. The cost of remedial services incurred by residents of licensed adult foster care homes and licensed homes for the aged shall be used in determining financial eligibility for the medically needy. Remedial services include basic self-care and rehabilitation training for a resident.

Sec. 1602. Medical services shall be provided to elderly and disabled persons with incomes less than or equal to 100% of the official poverty line, pursuant to the state's option to elect such coverage set out at section 1902(a)(10)(A)(ii) and (m) of title XIX, chapter 531, 49 Stat. 620, 42 U.S.C. 1396a.

Sec. 1603. (1) The department may establish a program for persons to purchase medical coverage at a rate determined by the department.

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

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

Sec. 1604. The mother of an unborn child shall be eligible for medical services benefits for herself and her child if all other eligibility factors are met. To be eligible for these benefits, the applicant shall provide medical evidence of her pregnancy. If she is unable to provide the documentation, payment for the examination may be at state expense. The department of community health shall undertake measures necessary to ensure that necessary prenatal care is provided to medical services eligible recipients.

Sec. 1605. (1) The protected income level for Medicaid coverage determined pursuant to section 106(1)(b)(iii) of the social welfare act, 1939 PA 280, MCL 400.106, shall be 100% of the related public assistance standard.

(2) The department shall notify the senate and house of representatives appropriations subcommittees on community health of any proposed revisions to the protected income level for Medicaid coverage related to the public assistance standard 90 days prior to implementation.

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

Sec. 1607. (1) An applicant for Medicaid, whose qualifying condition is pregnancy, shall immediately be presumed to be eligible for Medicaid coverage unless the preponderance of evidence in her application indicates otherwise.

(2) An applicant qualified as described in subsection (1) shall be given a letter of authorization to receive Medicaid covered services related to her pregnancy. In addition, the applicant shall receive a listing of Medicaid physicians and managed care plans in the immediate vicinity of the applicant's residence.

(3) An applicant that selects a Medicaid provider, other than a managed care plan, from which to receive pregnancy services, shall not be required to enroll in a managed care plan until the end of the second month postpartum.

(4) In the event that an applicant, presumed to be eligible pursuant to subsection (1), is subsequently found to be ineligible, a Medicaid physician or managed care plan that has been providing pregnancy services to an applicant under this section is entitled to reimbursement for those services until such time as they are notified by the department that the applicant was found to be ineligible for Medicaid.

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

Sec. 1608. The department shall make available to health care providers a pamphlet identifying patient rights and responsibilities described in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

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

Sec. 1611. (1) For care provided to medical services recipients with other third-party sources of payment, medical services reimbursement shall not exceed, in combination with such other resources, including Medicare, those amounts established for medical services-only patients. The medical services payment rate shall be accepted as payment in full. Other than an approved medical services copayment, no portion of a provider's charge shall be billed to the recipient or any person acting on behalf of the recipient. Nothing in this section shall be considered to affect the level of payment

from a third-party source other than the medical services program. The department shall require a nonenrolled provider to accept medical services payments as payment in full.

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

Sec. 1612. (1) It is the intent of the legislature that a uniform Medicaid billing form be developed by the department in consultation with affected Medicaid providers. Every 2 months, the department shall provide reports to members of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the progress of this initiative.

(2) HMOs that contract with the department to provide services to the Medicaid population shall adhere to the time frames for payment of clean claims as defined in section 111i(2)(a) of 2000 PA 187 submitted by health professionals and facilities and provide notice of any defect in claims submitted as specified in section 111i of 2000 PA 187.

Sec. 1613. (1) The workgroup established in section 1703 of 2000 PA 296 shall continue until the rebasing of the Medicaid fee schedule for physician and outpatient hospital services is completed.

(2) The workgroup shall provide a bimonthly report, beginning October 1, 2001, to the senate and house of representatives appropriations subcommittees on community health and senate and house fiscal agencies, of the activities of the workgroup and the expected date for the completion of the rebasing.

Sec. 1614. The department may rebase Medicaid fee for service rates for inpatient hospital services in fiscal year 2001-2002 if, in the aggregate for inpatient services, the rebasing is budget neutral.

Sec. 1620. (1) Effective October 1, 2001, the pharmaceutical dispensing fee shall be \$3.77 or the usual or customary cash charge, whichever is less. If a Medicaid recipient is 21 years of age or older, the department shall require a \$0.50 per prescription copayment for a generic drug and a copayment of \$3.00 or less for a brand name drug for which an equivalent generic drug is available, except as prohibited by federal or state law or regulation.

(2) The state shall reimburse the provider for the amount of a copayment if a Medicaid recipient is unable to pay that amount. If federal law prohibits that reimbursement, the prescription copayments in subsection (1) shall revert to the \$1.00 per prescription copayment described in 2000 PA 187, effective October 1, 2001.

Sec. 1621. (1) The department may implement prospective drug utilization review and disease management systems. The prospective drug utilization review and disease management systems authorized by this subsection shall have physician oversight, shall focus on patient, physician, and pharmacist education, and shall be developed in consultation with the national pharmaceutical council, Michigan state medical society, Michigan association of osteopathic physicians, Michigan pharmacists' association, Michigan health and hospital association, and Michigan nurses' association.

(2) This section does not authorize or allow therapeutic substitution.

Sec. 1622. The department may implement a mail-order pharmacy program for the noncapitated portion of the Medicaid program after a study by the department is submitted to the house of representatives and senate appropriations subcommittees on community health and after the repeal of section 17763(a) of the public health code, 1978 PA 368, MCL 333.17763.

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

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

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

Sec. 1626. The department, in conjunction with community mental health services programs, shall establish a Medicaid psychotropic drug utilization advisory committee which shall consist of 1 representative from the mental health and substance abuse services administration, 1 representative from the medical services administration, 1 representative from the Michigan association of community mental health boards, 1 representative from the Michigan pharmacists association, 1 representative from the Michigan state medical society, 1 representative from the Michigan association of osteopathic physicians, 1 representative from the Michigan psychiatric society, 2 representatives from the pharmaceutical industry, and 2 representatives appointed by the Michigan partners for patient advocacy to represent

the concerns of consumer, family, advocacy, and children's groups. The committee shall maintain a liaison with the Medicaid drug utilization review board and shall report to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies not later than September 30, 2002.

Sec. 1627. (1) The department shall use procedures and rebates amounts specified under section 1927 of title XIX of the social security act, 42 U.S.C. 1396r-8, to secure quarterly rebates from pharmaceutical manufacturers for outpatient drugs dispensed to participants in state medical program and children's special health care services.

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

Sec. 1628. It is the intent of the legislature that if the savings for Medicaid pharmacy rebates exceed the amount budgeted in this act, the savings shall first be used to offset any increase in pharmacy costs above that budgeted in this act and then to support and expand coverage under the EPIC program.

Sec. 1629. (1) From the funds appropriated in part 1 for the elder prescription insurance coverage program, the department shall provide prescription drug coverage to noninstitutionalized Michigan residents 65 years of age or older with income at or below 200% of the federal poverty guideline pursuant to the elder prescription insurance coverage act, 2000 PA 499, MCL 550.2001 to 550.2009. The Michigan emergency pharmaceutical programs for seniors in 2000 PA 296 shall be continued until the EPIC program is implemented.

(2) The department shall provide quarterly reports on the number of persons enrolled in the EPIC program, the year-to-date expenditures for the EPIC program, and projected annual expenditures for the EPIC program to the house of representatives and senate appropriations subcommittees on mental health, and the house and senate fiscal agencies.

(3) The department shall immediately establish a pharmaceutical rebate recovery initiative for the EPIC program. This initiative shall be based on, and be no more restrictive than, the existing Medicaid pharmaceutical rebate program.

(4) Pharmaceutical rebate revenue received under this initiative shall be used to offset the cost of the EPIC program, and in succeeding fiscal years, may be used to expand coverage of the EPIC program if so appropriated by the legislature.

Sec. 1630. Medicaid adult dental services, podiatric services, and chiropractic services shall continue at not less than the level in effect on October 1, 1996, except that reasonable utilization limitations may be adopted in order to prevent excess utilization. The department shall not impose utilization restrictions on chiropractic services unless a recipient has exceeded 18 office visits within 1 year.

Sec. 1631. The department shall require copayments on dental, podiatric, chiropractic, vision, and hearing aid services provided to Medicaid recipients, except as prohibited by federal or state law or regulation.

Sec. 1633. From the funds appropriated in part 1 for auxiliary medical services, the department shall expand the healthy kids dental program statewide if funds become available specifically for expansion of the program.

Sec. 1634. (1) From the funds appropriated in part 1 for ambulance services, the department shall continue the 5% increase in payment rates for ambulance services implemented in fiscal year 2000-2001.

(2) Effective October 1, 2001, the department shall implement a surcharge payable for all allowable ambulance runs made for Medicaid recipients excluding those recipients enrolled in Medicaid health maintenance organizations.

(3) This surcharge shall be based on average mileage per ambulance run and shall be structured so as to not exceed \$1,000,000.00 in total payments.

Sec. 1640. The department of community health shall distribute \$695,000.00 to children's hospitals that have a high indigent care volume. The amount to be distributed to any given hospital shall be based on a formula determined by the department of community health.

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

Sec. 1642. The department may make separate payments directly to qualifying hospitals serving a disproportionate share of indigent patients, and to hospitals providing graduate medical education training programs. If direct payment for GME and DSH is made to qualifying hospitals for services to Medicaid clients, hospitals will not include GME costs or DSH payments in their contracts with HMOs.

Sec. 1643. Of the funds appropriated in part 1 for graduate medical education in the hospital services and therapy line item appropriation, \$3,635,100.00 shall be allocated for the psychiatric residency training program that establishes and maintains collaborative relations with the schools of medicine at Michigan State University and Wayne State University.

Sec. 1644. (1) From the funds appropriated in part 1 for the rural health initiative, \$5,220,000.00 shall be allocated as an outpatient adjustor payment to be paid directly to hospitals in rural counties in proportion to each hospital's Medicaid and indigent patient population. One hundred fifty thousand dollars shall be allocated for free clinics in rural areas as designated by the federal government or such designation as may be modified by the department. These funds shall be allocated consistent with the requirements of section 1507 of this act. Two million dollars of the rural health initiative funds may be allocated for defibrillator grants, EMT training and support, or other similar programs. Four and one-half million dollars shall be allocated to defray the costs of construction and operation of health care clinics on Beaver Island and Mackinac Island.

(2) Except as otherwise specified in this section, rural is defined as a city, town, village, or township with a population of not more than 15,000, including those entities if located within a metropolitan statistical area.

Sec. 1645. (1) The outpatient hospital fee adjustor totaling \$16,511,000.00 in fiscal year 2000-2001 to hospitals that are under contract with health maintenance organizations is continued in fiscal year 2001-2002. Up to \$2,500,000.00 of this amount may be utilized to reimburse HMOs that can demonstrate that they have suffered a financial loss due to reimbursing noncontracting hospitals at fee-for-service rates rather than on a per diem basis.

(2) The outpatient hospital fee adjustor shall be paid to hospitals in the following proportion:

(a) 60% of the amount allocated shall be paid to hospitals based on the volume of outpatient services delivered through Medicaid managed care plans.

(b) 40% of the amount allocated shall be paid to hospitals based on the volume of outpatient services delivered under fee-for-service payment rates.

Sec. 1647. From the funds appropriated in part 1 for hospital services, the department shall allocate for graduate medical education not less than was allocated for graduate medical education in fiscal year 2000-2001.

Sec. 1648. The department shall maintain an automated toll-free phone line to enable medical providers to verify the eligibility status of Medicaid recipients. There shall be no charge to providers for the use of the toll-free phone line.

Sec. 1649. From the funds appropriated in part 1 for medical services, the department shall establish, breast and cervical cancer treatment coverage for women up to 250% of the federal poverty level, who are under age 65, and who are not otherwise covered by insurance. Such coverage shall be provided to women who have been screened through the centers for disease control breast and cervical cancer early detection program, and are found to have breast or cervical cancer, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354 of the 106th Congress.

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

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

(3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to mandatory enrollment at least through the current prescribed course of treatment, subject to periodic review of continued eligibility.

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

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

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

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

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

(c) A health plans advisory council is functioning that meets all applicable federal and state requirements for a medical care advisory committee. The council shall review at least quarterly the implementation of the department's managed care plans.

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

(e) Enrollment of recipients of children's special health care services in HMOs shall be voluntary during fiscal year 2001-2002.

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

Sec. 1654. (1) Medicaid HMOs shall establish an ongoing internal quality assurance program for health care services provided to Medicaid recipients which includes all of the following:

(a) An emphasis on health outcomes.

(b) Establishment of written protocols for utilization review based on current standards of medical practice.

(c) Review by physicians and other health care professionals of the process followed in the provision of the health care services.

(d) Evaluation of the continuity and coordination of care that enrollees receive.

(e) Mechanisms to detect overutilization and underutilization of services.

(f) Actions to improve quality and assess the effectiveness of the action through systematic follow-up.

(g) Provision of information on quality and outcome measures to facilitate enrollee comparison and choice of health coverage options.

(h) Ongoing evaluation of the plans' effectiveness.

(i) Consumer involvement in the development of the quality assurance program and consideration of enrollee complaints and satisfaction survey results.

(2) Medicaid HMOs shall apply for accreditation by an appropriate external independent accrediting organization requiring standards recognized by the department once those HMOs have met the application requirements. The state shall accept accreditation of an HMO by an approved accrediting organization as proof that the HMO meets some or all of the state's requirements, if the state determines that the accrediting organization's standards meet or exceed the state's requirements.

(3) Medicaid HMOs shall report encounter data, including data on inpatient and outpatient hospital care, physician visits, pharmaceutical services, and other services specified by the department.

(4) Medicaid HMOs shall assure that all covered services are available and accessible to enrollees with reasonable promptness and in a manner that assures continuity. Medically necessary services shall be available and accessible 24 hours a day and 7 days a week. HMOs shall continue to develop procedures for determining medical necessity which may include a prior authorization process.

(5) Medicaid HMOs shall provide for reimbursement of HMO covered services delivered other than through the HMO's providers if medically necessary and approved by the HMO, immediately required, and that could not be reasonably obtained through the HMO's providers on a timely basis. Such services shall be considered approved if the HMO does not respond to a request for authorization within 24 hours of the request. Reimbursement shall not exceed the Medicaid fee-for-service payment for those services.

(6) Medicaid HMOs shall provide access to appropriate providers, including qualified specialists for all medically necessary services.

(7) Medicaid HMOs shall provide the department with a demonstration of the plan's capacity to adequately serve the HMO's expected enrollment of Medicaid enrollees.

(8) Medicaid HMOs shall provide assurances to the department that it will not deny enrollment to, expel, or refuse to reenroll any individual because of the individual's health status or need for services, and that it will notify all eligible persons of those assurances at the time of enrollment.

(9) Medicaid HMOs shall provide procedures for hearing and resolving grievances between the HMO and members enrolled in the HMO on a timely basis.

(10) Medicaid HMOs shall meet other standards and requirements contained in state laws, administrative rules, and policies promulgated by the department.

(11) Medicaid HMOs shall develop written plans for providing nonemergency medical transportation services funded through supplemental payments made to the plans by the department, and shall include information about transportation in their member handbook.

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

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

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

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

(3) Annual reports summarizing the problems and complaints reported and their resolution shall be provided to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, the state budget office, and the department's health plans advisory council.

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

(2) If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's HMO prior to admitting the recipient.

(3) Subsections (1) and (2) shall not be construed as a requirement to alter an existing agreement between an HMO and their contracting hospitals nor as a requirement that an HMO must reimburse for services that are not considered to be medically necessary.

Sec. 1658. (1) In lieu of implementing per diems in policy bulletin MSA 01-03 related to Medicaid conditions of participation for hospitals and removing references to per diem payments, the department may utilize up to \$2,500,000.00 from the outpatient adjustor and \$1,500,000.00 from available lapses in the health plan services line to reimburse HMOs that can demonstrate that they have suffered a financial loss due to reimbursing noncontracting hospitals at fee-for-service rates rather than on a per diem basis. Medicaid notices of proposed policies 0039-Hospital and 0004-Hospital, relating to payments under the outpatient hospital adjustor and graduate medical education payments respectively, shall have all references to per diem payments deleted.

(2) It is the intent of the legislature that HMOs shall have contracts with hospitals within a reasonable distance from their enrollees. If a hospital does not contract with 1 or more HMOs, in which it has no financial interest and whose facility is in a service area with 1 or more HMOs, that hospital shall allow for the admission of HMO enrollees by a physician under contract with excluded HMOs who has admitting privileges at that hospital.

(3) In the absence of a contract with a hospital, an HMO shall reimburse that hospital at Medicaid fee-for-service rates for medically necessary and appropriately authorized services, arranged by a physician under contract with the HMO and who has admitting privileges at that hospital. The department shall reimburse the HMO the differential between the actuarially equivalent per diem rate and the actual Medicaid fee-for-service payment that was paid to the hospital by the HMO.

(4) The conditions specified in subsection (3) shall only apply to those HMOs that can certify that the capitation rates, on which their bid for inclusion in the state's Medicaid managed care program was made, were based on per diem and not fee-for-service estimates for inpatient hospital services.

Sec. 1659. The following sections are the only ones that shall apply to the following Medicaid managed care programs, including the comprehensive plan, children's special health care services plan, MI Choice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 402, 404, 413, 414, 418, 1612, 1642, 1650, 1651, 1653, 1654, 1655, 1656, 1657, 1658, 1660, 1661, and 1662.

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

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

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

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

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

Sec. 1661. (1) The department shall assure that all Medicaid eligible children and pregnant women have timely access to MSS/ISS services. Medicaid HMOs shall assure that maternal support service screening is available to their pregnant members and that those women found to meet the maternal support service high-risk criteria are offered maternal support services. Local health departments shall assure that maternal support service screening is available for Medicaid pregnant women not enrolled in an HMO and that those women found to meet the maternal support service high-risk criteria are offered maternal support services or are referred to a certified maternal support service provider.

(2) The department shall prohibit HMOs from requiring prior authorization of their contracted providers for any EPSDT screening and diagnosis service, for any MSS/ISS screening referral, or for up to 3 MSS/ISS service visits.

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

Sec. 1662. (1) The department shall require the external quality review contractor to conduct a review of all EPSDT components provided to children from a statistically valid sample of health plan medical records.

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

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

(4) The department shall provide training and technical assistance workshops on EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

Sec. 1663. (1) Local health departments and HMOs shall work with interested hospitals in their area on training and coordination to identify and make MSS/ISS referrals.

(2) Local health departments shall work with interested hospitals, school-based health centers, clinics, other community organizations, and local family independence agency offices in their area on training and coordination to distribute and facilitate the completion of MICHild and Healthy Kids application forms for persons who are potentially eligible for the program.

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

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

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

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

(3) The department may enter into contracts to obtain certain MICHild services from community mental health service programs.

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

Sec. 1671. From the funds appropriated in part 1, the department shall continue a comprehensive approach to the marketing and outreach of the MICHild program. The marketing and outreach required under this section shall be coordinated with current outreach, information dissemination, and marketing efforts and activities conducted by the department.

Sec. 1672. The department may provide up to 1 year of continuous eligibility to children eligible for the MICHild program unless the status of the children’s family changes and its members no longer meet the eligibility criteria as specified in the federally approved MICHild state plan.

Sec. 1673. The department may establish premiums for MICHild eligible persons in families with income above 150% of the federal poverty level. The monthly premiums shall not exceed \$5.00 for a family.

Sec. 1674. The department shall not require copayments under the MICHild program.

Sec. 1675. Children whose category of eligibility changes between the Medicaid and MICHild programs shall be assured of keeping their current health care providers through the current prescribed course of treatment for up to 1 year, subject to periodic reviews by the department if the beneficiary has a serious medical condition and is undergoing active treatment for that condition.

Sec. 1676. To be eligible for the MICHild program, a child must be residing in a family with an adjusted gross income of less than or equal to 200% of the federal poverty level. The department’s verification policy shall be used to determine eligibility.

Sec. 1677. The MICHild program shall provide all benefits available under the state employee insurance plan that are delivered through contracted providers and consistent with federal law, including, but not limited to, the following medically necessary services:

(a) Inpatient mental health services, other than substance abuse treatment services, including services furnished in a state-operated mental hospital and residential or other 24-hour therapeutically planned structured services.

(b) Outpatient mental health services, other than substance abuse services, including services furnished in a state-operated mental hospital and community-based services.

(c) Durable medical equipment and prosthetic and orthotic devices.

(d) Dental services as outlined in the approved MICHild state plan.

(e) Substance abuse treatment services that may include inpatient, outpatient, and residential substance abuse treatment services.

(f) Care management services for mental health diagnoses.

(g) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(h) Emergency ambulance services.

Sec. 1678. The department shall explore options under the federal state children’s health insurance program (SCHIP), including waiver requests, to extend coverage to low-income parents of MICHild eligible children. The department may also explore options to increase the Medicaid income disregard for parents of Medicaid or MICHild eligible children who have income up to 100% of the federal poverty level. The department shall issue a report that identifies the estimated number of persons to be served and the projected costs for the various health care coverage

options considered to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies by March 1, 2002.

Sec. 1680. (1) It is the intent of the legislature that payment increases for enhanced wages and new or enhanced employee benefits provided through the Medicaid nursing home wage pass-through program in previous years be continued in fiscal year 2001-2002.

(2) The department shall provide a report to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies regarding the amount of nursing home employee wage and benefit increases provided through the nursing home wage pass-through program in fiscal year 2000-2001.

Sec. 1681. (1) The department may fund home and community-based services in lieu of nursing home services, for individuals seeking long-term care services, from the nursing home or personal care in-home services line items.

(2) The department shall provide a report on the pilot project to coordinate services between the home and community-based services and the adult home help programs to the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies by April 1, 2002.

Sec. 1682. (1) The department shall implement enforcement actions as specified in the nursing facility enforcement provisions of section 1919 of title XIX, chapter 531, 49 Stat. 620, 42 U.S.C. 1396r.

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

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

Sec. 1683. The department shall promote activities that preserve the dignity and rights of terminally ill and chronically ill individuals. Priority shall be given to programs, such as hospice, that focus on individual dignity and quality of care provided persons with terminal illness and programs serving persons with chronic illnesses that reduce the rate of suicide through the advancement of the knowledge and use of improved, appropriate pain management for these persons; and initiatives that train health care practitioners and faculty in managing pain, providing palliative care, and suicide prevention.

Sec. 1684. The long-term care working group established in section 1657 of 1998 PA 336 shall continue to exist to review the allocation of the long-term care innovations grant funding and to monitor the implementation of the demonstration projects being funded. The department shall not implement a long-term care plan until the expiration of 24 days during which at least 1 house of the legislature convenes after the long-term care working group has submitted the written long-term care plan to the senate majority leader, the speaker of the house, the senate and house appropriations subcommittees on community health, and the state budget director.

Sec. 1685. All nursing home rates, class I and class III, must have their respective fiscal year rate set 30 days prior to the beginning of their rate year. Rates may take into account the most recent cost report prepared and certified by the preparer, provider corporate owner or representative as being true and accurate, and filed timely, within 5 months of the fiscal year end in accordance with Medicaid policy. If the audited version of the last report is available, it shall be used. Any rate factors based on the filed cost report may be retroactively adjusted upon completion of the audit of that cost report.

Sec. 1686. (1) Medicaid payment rates for nursing home services that take effect on or after October 1, 2001 shall be based on a minimum resident occupancy requirement of 85%.

(2) A nursing home that removes beds to reduce its licensed bed capacity may remove the beds from anywhere in the facility and does not have to remove only beds adjacent to each other. The facility cost for space from which beds are removed to downsize wards or create private rooms shall remain as an allowable Medicaid cost. The department shall not require nursing home beds removed under this policy to remain out of service for more than 1 year, and a shorter period of time may be approved by the department.

Sec. 1688. (1) In consultation with the nursing home industry, the department shall conduct a study to address the apparent liability insurance increases for nursing homes. The study may include recommendations such as creating a self-insured fund, a catastrophic claim fund, a cost-settled Medicaid pass-through for liability insurance increases if not in the base rate, or implementing an alternative methodology. The department shall provide its findings and recommendations from this study to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director no later than April 1, 2002.

(2) The department shall allocate \$1,000,000.00 for capitalization purposes to establish a professional liability insurance product for Michigan nursing facilities that is consistent with the study recommendations in subsection (1).

Only nursing facilities that have Medicaid certified beds shall be able to participate in this insurance product. Premiums paid for this product are an allowable Medicaid cost to the extent allowed under state and federal law.

Sec. 1689. The department shall not impose a limit on per unit reimbursements to service providers that provide personal care or other services under the Medicaid home and community-based waiver program for the elderly and disabled. The department's per day per client reimbursement cap calculated in the aggregate for all services provided under the Medicaid home and community-based waiver is not a violation of this section.

Sec. 1690. (1) From the funds appropriated in part 1 for the indigent medical care program, the department shall establish a program that provides for the basic health care needs of indigent persons as delineated in the following subsections.

(2) Eligibility for this program is limited to the following:

(a) Persons currently receiving cash grants under either the family independence program or state disability assistance programs who are not eligible for any other public or private health care coverage.

(b) Any other resident of this state who currently meets the income and asset requirements for the state disability assistance program and is not eligible for any other public or private health care coverage.

(3) All potentially eligible persons, except those defined in subsection (2)(a), who shall be automatically enrolled, may apply for enrollment in this program at local family independence agency offices or other designated sites.

(4) The program shall provide for the following minimum level of services for enrolled individuals:

(a) Physician services provided in private, clinic, or outpatient office settings.

(b) Diagnostic laboratory and x-ray services.

(c) Pharmaceutical services.

(5) Notwithstanding subsection (2)(b), the state may continue to provide nursing facility coverage, including medically necessary ancillary services, to individuals categorized as permanently residing under color of law and who meet either of the following requirements:

(a) The individuals were medically eligible and residing in such a facility as of August 22, 1996 and qualify for emergency medical services.

(b) The individuals were Medicaid eligible as of August 22, 1996, and admitted to a nursing facility before a new eligibility determination was conducted by the family independence agency.

Sec. 1691. (1) From the funds appropriated in part 1, the department, subject to the requirements and limitations in this section, shall establish a funding pool of up to \$44,012,800.00 for the purpose of enhancing the aggregate payment for medical services hospital services.

(2) For a county with a population of more than 2,000,000 people, the department shall distribute \$44,012,800.00 to hospitals if \$15,026,700.00 is received by the state from such a county, which meets the criteria of an allowable state matching share as determined by applicable federal laws and regulations. If the state receives a lesser sum of an allowable state matching share from such a county, the amount distributed shall be reduced accordingly.

(3) The department may establish county-based, indigent health care programs that are at least equal in eligibility and coverage to the fiscal year 1996 state medical program.

(4) The department is authorized to establish and expand programs in counties that include rural, underserved areas if the expenditures for the programs do not increase state general fund/general purpose costs and local funds are provided.

(5) If a locally administered indigent health care program replaces the state medical program authorized by section 1690 for a given county on or before October 1, 1998, the state general fund/general purpose dollars allocated for that county under this section shall not be less than the general fund/general purpose expenditures for the state medical program in that county in the previous fiscal year.

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

(2) From the funds appropriated in part 1 for medical services school services payments, the department is authorized to do all of the following:

(a) Finance activities within the medical services administration related to this project.

(b) Reimburse participating school districts pursuant to the fund sharing ratios negotiated in the state-local agreements authorized in subsection (1).

(c) Offset general fund costs associated with the medical services program.

Sec. 1693. The special adjustor payments appropriation in part 1 may be increased if the department submits a medical services state plan amendment pertaining to this line item at a level higher than the appropriation. The department is authorized to appropriately adjust financing sources in accordance with the increased appropriation.

Sec. 1695. It is the sense of the legislature that disproportionate share hospital payments and other similar adjustor payments should be equitably distributed on a statewide basis. No later than February 1, 2002, the department shall provide a report to the chairs of the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies on the methodology used to distribute disproportionate share hospital payments and other similar adjustor payments. This report shall include the existing distribution of these funds by geographic location.

Sec. 1696. It is the intent of the legislature that the department implement by April 1, 2002, a magnetic card identification system for the Medicaid program that will assist in the eligibility verification process.

Sec. 1697. (1) As may be allowed by federal law or regulation, the department may use funds provided by a local or intermediate school district, which have been obtained from a qualifying health system, as the state match required for receiving federal Medicaid or children health insurance program funds. Any such funds received shall be used only to support new school-based or school-linked health services.

(2) A qualifying health system is defined as any health care entity licensed to provide health care services in the state of Michigan, that has entered into a contractual relationship with a local or intermediate school district to provide or manage school-based or school-linked health services.

Sec. 1698. From the funds appropriated in part 1 for medical services, \$25,000,000.00 is allocated from the Medicaid benefits trust fund established in the Michigan trust fund act, 2000 PA 489, MCL 12.251 to 12.256, due to the federal disallowance of claims related to school-based services.

PART 2B

PROVISIONS CONCERNING APPROPRIATIONS FOR FISCAL YEAR 2000-2001

Sec. 2201. Of the amount appropriated to medical services administration for the "Ticket to Work" initiative in 2000 PA 296, \$50,000.00 shall be considered a work project. Those funds shall not lapse on September 30, 2001 and shall be carried forward for the purpose of supporting expenditures for the "Ticket to Work" initiative in fiscal year 2001-2002.

Sec. 2202. The certificate of need commission shall take the necessary steps to remove the cap that currently exists in standards related to positron emission tomography. The commission shall accomplish this no later than September 11, 2001.

Sec. 2203. (1) From the funds appropriated in part 1 for state and local medical programs in 2000 PA 296, the department shall allocate 1-time funding of \$2,500,000.00 to hospitals in 3 communities with high infant mortality rates to improve access to prenatal and maternity care including labor and delivery for uninsured and Medicaid eligible women. The funding shall be available for 1 project in each of the following categories: a city or township with a population of not less than 250,000; a city or township with a population between 50,000 and 250,000; and a city or township with a population of less than 50,000. The funding for this purpose shall be considered a work project. These funds shall not lapse on September 30, 2001 and shall be carried forward for the purpose specified in this section.

(2) The criteria to be utilized in awarding the funds shall include the infant mortality rate for each community, the number and percentage of uninsured and Medicaid eligible births, the recent closure of neighboring hospitals that formerly provided maternity related services, and the commitment to provide outreach to at-risk women in collaboration with the local health departments, other locally-based agencies, or both.

Sec. 2204. (1) No later than September 30, 2001, the department shall submit changes to pharmacy policies for Medicaid recipients not enrolled in Medicaid HMOs to the chairpersons. These changes may reflect a composite of pharmacy best practices in use by HMOs under contract to provide managed medical care services to nonexempt Medicaid recipients.

(2) A changed policy described in subsection (1) shall not be more restrictive than those developed for the EPIC program. In addition, this section does not authorize or allow therapeutic substitution.

(3) Any changes described in subsection (1) shall become effective 30 days after the department submits these changes to the chairpersons unless 1 or both of the chairpersons disapprove of the changes. If both of the chairpersons disapprove, the changes do not become effective. If only 1 of the chairpersons disapproves, the chairpersons shall submit the changes to the speaker of the house and the majority leader of the senate, and the changes shall become effective 15 days after that submission to the speaker of the house and the majority leader of the senate unless both the speaker of the house and the majority leader of the senate disapprove.

(4) As used in this section, "chairpersons" means the chairpersons of the senate and house of representatives appropriations subcommittees on community health.

Sec. 2205. The certificate of need commission shall take the necessary steps to grant an exemption from the 2-mile replacement zone for hospital relocation if the proposal for relocation meets all of the following conditions:

(a) The hospital seeking to move more than 2 miles from its existing location shall be located in an area zoned residential.

(b) The hospital has demonstrated a thorough search for a suitable site within the 2-mile replacement zone.

(c) The municipality in which the hospital is located agrees to the relocation plan.

(d) The municipality to which the hospital wishes to move approves of the relocation plan.

(e) The new site shall be in the same county as the previous location.

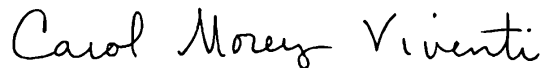
(f) The population of the county shall have a minimum of 500,000 residents, but not more than 1,000,000 residents.

Sec. 2206. The department shall take the necessary steps to recalculate the acute care bed need using the methodology described in section 4 of the certificate of need review standards for hospital beds that became effective on May 10, 2001. The acute care bed need shall be recalculated using the latest available data. The department shall complete the recalculation by August 31, 2001 and shall present it to the certificate of need commission at its first meeting after August 31, 2001.

This act is ordered to take immediate effect.



Clerk of the House of Representatives.



Secretary of the Senate.

Approved _____

Governor.