Act No. 330
Public Acts of 2006
Approved by the Governor
August 10, 2006
Filed with the Secretary of State
August 10, 2006
EFFECTIVE DATE: August 10, 2006

STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Senators Cherry and Emerson

ENROLLED SENATE BILL No. 1083

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, 2007; 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

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, 2007, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH

APPROPRIATION SUMMARY:		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	4,658.1	
Average population	1,109.0	
GROSS APPROPRIATION		$ 11,196,157,400
Interdepartmental grant revenues:		
Total interdepartmental grants and intradepartmental transfers		37,286,100
ADJUSTED GROSS APPROPRIATION		$ 11,158,871,300
Federal revenues:		
Total federal revenues		6,042,584,700
Special revenue funds:		
Total local revenues		241,177,400
Total private revenues		63,826,900
Merit award trust fund		175,800,000
Total other state restricted revenues		1,695,399,600
State general fund/general purpose		$ 2,940,082,700

	For Fiscal Year Ending Sept. 30, 2007
Sec. 102. DEPARTMENTWIDE ADMINISTRATION	
Full-time equated unclassified positions 6.0	
Full-time equated classified positions 208.0	
Director and other unclassified—6.0 FTE positions	$ 581,500
Community health advisory council	7,000
Departmental administration and management—198.0 FTE positions	22,489,900
Worker's compensation program	10,600,000
Human resources optimization user charges	277,600
Rent and building occupancy	10,877,700
Developmental disabilities council and projects—10.0 FTE positions	2,724,000
GROSS APPROPRIATION	$ 47,557,700
Appropriated from:	
Federal revenues:	
Total federal revenues	11,694,000
Special revenue funds:	
Total private revenues	35,900
Total other state restricted revenues	3,488,400
State general fund/general purpose	$ 32,339,400
Sec. 103. MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS	
Full-time equated classified positions 113.0	
Mental health/substance abuse program administration—112.0 FTE positions	$ 12,507,600
Consumer involvement program	189,100
Gambling addiction—1.0 FTE position	3,500,000
Protection and advocacy services support	777,400
Mental health initiatives for older persons	1,291,200
Community residential and support services	2,906,800
Highway safety projects	400,000
Federal and other special projects	1,902,200
Family support subsidy	19,036,000
Housing and support services	7,806,800
Methamphetamine cleanup fund	175,000
GROSS APPROPRIATION	$ 50,492,100
Appropriated from:	
Federal revenues:	
Total federal revenues	32,185,100
Special revenue funds:	
Total private revenues	190,000
Total other state restricted revenues	3,500,000
State general fund/general purpose	$ 14,617,000
Sec. 104. COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS	
Full-time equated classified positions 9.5	
Medicaid mental health services	$ 1,797,294,900
Community mental health non-Medicaid services	317,772,300
Medicaid adult benefits waiver	40,000,000
Multicultural services	5,163,800
Medicaid substance abuse services	35,622,900
Respite services	1,000,000
CMHSP, purchase of state services contracts	128,681,500
Civil service charges	1,765,500
Federal mental health block grant—2.5 FTE positions	15,355,000
State disability assistance program substance abuse services	2,509,800
Community substance abuse prevention, education and treatment programs	85,919,100
Children's waiver home care program	19,549,800
Omnibus reconciliation act implementation—7.0 FTE positions	12,505,200

		For Fiscal Year Ending Sept. 30, 2007
Children with serious emotional disturbance waiver	$	570,000
GROSS APPROPRIATION	$	2,463,709,800
Appropriated from:		
Federal revenues:		
Total federal revenues		1,164,470,700
Special revenue funds:		
Total local revenues		26,072,100
Total other state restricted revenues		112,208,900
State general fund/general purpose	$	1,160,958,100

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

Total average population 1,109.0		
Full-time equated classified positions 2,900.3		
Caro regional mental health center - psychiatric hospital - adult—482.3 FTE positions	$	41,511,600
Average population 179.0		
Kalamazoo psychiatric hospital - adult—466.6 FTE positions		40,392,200
Average population 186.0		
Walter P. Reuther psychiatric hospital - adult—437.3 FTE positions		40,549,700
Average population 236.0		
Hawthorn center - psychiatric hospital - children and adolescents—219.0 FTE positions		19,483,900
Average population 74.0		
Mount Pleasant center - developmental disabilities—472.7 FTE positions		42,954,900
Average population 209.0		
Center for forensic psychiatry—493.0 FTE positions		49,408,800
Average population 225.0		
Forensic mental health services provided to the department of corrections—318.4 FTE positions		36,018,600
Revenue recapture		750,000
IDEA, federal special education		120,000
Special maintenance and equipment		335,300
Purchase of medical services for residents of hospitals and centers		2,045,600
Closed site, transition, and related costs—11.0 FTE positions		712,300
Severance pay		216,900
Gifts and bequests for patient living and treatment environment		1,000,000
GROSS APPROPRIATION	$	275,499,800
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of corrections		36,018,600
Federal revenues:		
Total federal revenues		35,269,100
Special revenue funds:		
CMHSP, purchase of state services contracts		128,681,500
Other local revenues		15,548,400
Total private revenues		1,000,000
Total other state restricted revenues		10,229,300
State general fund/general purpose	$	48,752,900

Sec. 106. PUBLIC HEALTH ADMINISTRATION

Full-time equated classified positions 86.4		
Public health administration—11.0 FTE positions	$	1,802,400
Minority health grants and contracts—3.0 FTE positions		1,592,500
Vital records and health statistics—72.4 FTE positions		7,658,400
GROSS APPROPRIATION	$	11,053,300
Appropriated from:		
Interdepartmental grant revenues:		
Interdepartmental grant from the department of human services		724,100

	For Fiscal Year Ending Sept. 30, 2007
Federal revenues:	
Total federal revenues	$ 2,854,000
Special revenue funds:	
Total other state restricted revenues	5,972,700
State general fund/general purpose	$ 1,502,500
Sec. 107. HEALTH POLICY, REGULATION, AND PROFESSIONS	
Full-time equated classified positions....405.6	
Health systems administration—193.6 FTE positions	$ 21,620,000
Emergency medical services program state staff—8.5 FTE positions	1,423,500
Radiological health administration—21.4 FTE positions	2,506,700
Substance abuse program administration—1.0 FTE position	64,400
Emergency medical services grants and services—7.0 FTE positions	588,900
Health professions—125.0 FTE positions	15,205,400
Health policy, regulation, and professions administration—29.7 FTE positions	5,366,800
Nurse scholarship, education, and research program—3.0 FTE positions	903,800
Certificate of need program administration—14.0 FTE positions	1,726,400
Rural health services—1.0 FTE position	1,390,500
Michigan essential health provider	1,847,100
Primary care services—1.4 FTE positions	2,265,500
GROSS APPROPRIATION	$ 54,909,000
Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from the department of treasury, Michigan state hospital finance authority	113,000
Federal revenues:	
Total federal revenues	22,559,600
Special revenue funds:	
Total local revenues	227,700
Total private revenues	150,000
Total other state restricted revenues	24,150,900
State general fund/general purpose	$ 7,707,800
Sec. 108. INFECTIOUS DISEASE CONTROL	
Full-time equated classified positions....49.0	
AIDS prevention, testing, and care programs—12.0 FTE positions	$ 37,428,800
Immunization local agreements	13,990,300
Immunization program management and field support—15.0 FTE positions	1,930,700
Pediatric AIDS prevention and control	1,224,800
Sexually transmitted disease control local agreements	3,423,200
Sexually transmitted disease control management and field support—22.0 FTE positions	3,624,900
GROSS APPROPRIATION	$ 61,622,700
Appropriated from:	
Federal revenues:	
Total federal revenues	40,921,800
Special revenue funds:	
Total private revenues	7,997,900
Total other state restricted revenues	8,575,800
State general fund/general purpose	$ 4,127,200
Sec. 109. LABORATORY SERVICES	
Full-time equated classified positions....122.0	
Bovine tuberculosis—2.0 FTE positions	$ 500,000
Laboratory services—120.0 FTE positions	15,543,700
GROSS APPROPRIATION	$ 16,043,700
Appropriated from:	
Interdepartmental grant revenues:	
Interdepartmental grant from the department of environmental quality	430,400

	For Fiscal Year Ending Sept. 30, 2007
Federal revenues:	
Total federal revenues	$ 3,093,200
Special revenue funds:	
Total other state restricted revenues	5,420,200
State general fund/general purpose	$ 7,099,900
Sec. 110. EPIDEMIOLOGY	
Full-time equated classified positions....134.5	
AIDS surveillance and prevention program	$ 2,419,900
Asthma prevention and control—2.3 FTE positions	1,055,300
Bioterrorism preparedness—76.1 FTE positions	50,605,200
Epidemiology administration—41.1 FTE positions	6,640,100
Lead abatement program—7.0 FTE positions	2,143,400
Newborn screening follow-up and treatment services—8.0 FTE positions	3,862,300
Tuberculosis control and recalcitrant AIDS program	867,000
GROSS APPROPRIATION	$ 67,593,200
Appropriated from:	
Federal revenues:	
Total federal revenues	61,099,500
Special revenue funds:	
Total private revenues	25,000
Total other state restricted revenues	4,307,600
State general fund/general purpose	$ 2,161,100
Sec. 111. LOCAL HEALTH ADMINISTRATION AND GRANTS	
Implementation of 1993 PA 133, MCL 333.17015	$ 100,000
Local health services	220,000
Local public health operations	40,618,400
Medical services cost reimbursement to local health departments	3,110,000
GROSS APPROPRIATION	$ 44,048,400
Appropriated from:	
Federal revenues:	
Total federal revenues	3,110,000
Special revenue funds:	
Total local revenues	5,150,000
Total other state restricted revenues	243,500
State general fund/general purpose	$ 35,544,900
Sec. 112. CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION	
Full-time equated classified positions....65.5	
African-American male health initiative	$ 106,700
AIDS and risk reduction clearinghouse and media campaign	1,576,000
Alzheimer's information network	412,900
Cancer prevention and control program—15.3 FTE positions	15,145,400
Chronic disease prevention—10.0 FTE positions	4,416,900
Diabetes and kidney program—11.1 FTE positions	3,726,400
Health education, promotion, and research programs—9.3 FTE positions	770,000
Injury control intervention project—1.0 FTE position	100,900
Michigan Parkinson's foundation	50,000
Morris Hood Wayne State University diabetes outreach	400,000
Physical fitness, nutrition, and health	700,000
Public health traffic safety coordination—1.7 FTE positions	584,900
Smoking prevention program—15.1 FTE positions	5,632,400
Tobacco tax collection and enforcement	610,000
Violence prevention—2.0 FTE positions	1,896,900
GROSS APPROPRIATION	$ 36,129,400

	For Fiscal Year Ending Sept. 30, 2007
Appropriated from:	
Federal revenues:	
Total federal revenues	$ 19,987,500
Special revenue funds:	
Total private revenues	85,000
Total other state restricted revenues	14,901,700
State general fund/general purpose	$ 1,155,200
Sec. 113. FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES	
Full-time equated classified positions....50.4	
Childhood lead program—6.8 FTE positions	$ 2,536,100
Dental programs	485,400
Dental program for persons with developmental disabilities	151,000
Early childhood collaborative secondary prevention	524,000
Family, maternal, and children's health services administration—41.6 FTE positions	4,780,600
Family planning local agreements	12,270,300
Local MCH services	7,264,200
Migrant health care	272,200
Pregnancy prevention program	5,733,400
Prenatal care outreach and service delivery support	3,049,300
School health and education programs	500,000
Special projects—2.0 FTE positions	6,214,900
Sudden infant death syndrome program	321,300
GROSS APPROPRIATION	$ 44,102,700
Appropriated from:	
Federal revenues:	
Total federal revenues	30,411,300
Special revenue funds:	
Total other state restricted revenues	8,664,000
State general fund/general purpose	$ 5,027,400
Sec. 114. WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM	
Full-time equated classified positions....41.0	
Women, infants, and children program administration and special projects—41.0 FTE positions	$ 6,681,000
Women, infants, and children program local agreements and food costs	179,272,000
GROSS APPROPRIATION	$ 185,953,000
Appropriated from:	
Federal revenues:	
Total federal revenues	132,714,900
Special revenue funds:	
Total private revenues	53,238,100
State general fund/general purpose	$ 0
Sec. 115. CHILDREN'S SPECIAL HEALTH CARE SERVICES	
Full-time equated classified positions....44.0	
Children's special health care services administration—44.0 FTE positions	$ 4,296,900
Amputee program	184,600
Bequests for care and services	1,889,100
Outreach and advocacy	3,773,500
Nonemergency medical transportation	1,289,100
Medical care and treatment	173,641,600
GROSS APPROPRIATION	$ 185,074,800
Appropriated from:	
Federal revenues:	
Total federal revenues	90,016,200
Special revenue funds:	
Total private revenues	1,000,000
Total other state restricted revenues	2,584,500
State general fund/general purpose	$ 91,474,100

		For Fiscal Year Ending Sept. 30, 2007
Sec. 116. OFFICE OF DRUG CONTROL POLICY		
Full-time equated classified positions....16.0		
Drug control policy—16.0 FTE positions	$	2,104,600
Anti-drug abuse grants		16,105,400
Interdepartmental grant to judiciary for drug treatment courts		1,800,000
GROSS APPROPRIATION	$	20,010,000
Appropriated from:		
Federal revenues:		
Total federal revenues		18,399,500
State general fund/general purpose	$	1,610,500
Sec. 117. CRIME VICTIM SERVICES COMMISSION		
Full-time equated classified positions....10.0		
Grants administration services—10.0 FTE positions	$	1,087,500
Justice assistance grants		13,000,000
Crime victim rights services grants		10,800,000
GROSS APPROPRIATION	$	24,887,500
Appropriated from:		
Federal revenues:		
Total federal revenues		14,770,300
Special revenue funds:		
Total other state restricted revenues		10,117,200
State general fund/general purpose	$	0
Sec. 118. OFFICE OF SERVICES TO THE AGING		
Full-time equated classified positions....36.5		
Commission (per diem $50.00)	$	10,500
Office of services to aging administration—36.5 FTE positions		5,324,100
Community services		35,204,200
Nutrition services		37,290,500
Foster grandparent volunteer program		2,813,500
Retired and senior volunteer program		790,200
Senior companion volunteer program		2,021,200
Employment assistance		2,818,300
Respite care program		7,600,000
GROSS APPROPRIATION	$	93,872,500
Appropriated from:		
Federal revenues:		
Total federal revenues		52,251,400
Special revenue funds:		
Total private revenues		105,000
Merit award trust fund		5,000,000
Total other state restricted revenues		2,767,000
State general fund/general purpose	$	33,749,100
Sec. 119. MICHIGAN FIRST HEALTHCARE PLAN		
Michigan first healthcare plan	$	100,000,000
GROSS APPROPRIATION	$	100,000,000
Appropriated from:		
Federal revenues:		
Total federal revenues		100,000,000
State general fund/general purpose	$	0
Sec. 120. MEDICAL SERVICES ADMINISTRATION		
Full-time equated classified positions....366.4		
Medical services administration—366.4 FTE positions	$	70,072,300
Facility inspection contract - state police		132,800

		For Fiscal Year Ending Sept. 30, 2007
MIChild administration	$	4,327,800
Health information technology initiatives		9,500,000
GROSS APPROPRIATION	$	84,032,900
Appropriated from:		
Federal revenues:		
Total federal revenues		56,661,000
State general fund/general purpose	$	27,371,900

Sec. 121. MEDICAL SERVICES

Hospital services and therapy	$	1,124,379,500
Hospital disproportionate share payments		50,000,000
Physician services		276,530,100
Medicare premium payments		311,929,600
Pharmaceutical services		56,828,700
Home health services		5,580,300
Hospice services		64,181,300
Transportation		9,765,200
Auxiliary medical services		5,621,300
Dental services		101,750,800
Ambulance services		11,376,000
Long-term care services		1,594,415,800
Medicaid home- and community-based services waiver		100,000,000
Adult home help services		221,924,000
Personal care services		25,509,700
Program of all-inclusive care for the elderly		11,200,000
Single point of entry		9,000,000
Health plan services		2,484,260,000
MIChild program		46,575,600
Medicaid adult benefits waiver		122,239,500
County indigent care and third share plans		88,518,500
Federal Medicare pharmaceutical program		177,800,000
Promotion of healthy behavior waiver		10,000,000
Maternal and child health		20,279,500
Social services to the physically disabled		1,344,900
Subtotal basic medical services program		6,931,010,300
School-based services		76,235,400
Special Medicaid reimbursement		290,892,100
Subtotal special medical services payments		367,127,500
GROSS APPROPRIATION	$	7,298,137,800
Appropriated from:		
Federal revenues:		
Total federal revenues		4,130,819,100
Special revenue funds:		
Total local revenues		65,497,700
Merit award trust fund		170,800,000
Total other state restricted revenues		1,475,211,000
State general fund/general purpose	$	1,455,810,000

Sec. 122. INFORMATION TECHNOLOGY

Information technology services and projects	$	31,427,000
Michigan Medicaid information system		100
GROSS APPROPRIATION	$	31,427,100
Appropriated from:		
Federal revenues:		
Total federal revenues		19,296,500
Special revenue funds:		
Total other state restricted revenues		3,056,900
State general fund/general purpose	$	9,073,700

PART 2

PROVISIONS CONCERNING APPROPRIATIONS

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 2006-2007 is $4,811,282,300.00 and state spending from state resources to be paid to units of local government for fiscal year 2006-2007 is $1,317,715,000.00. The itemized statement below identifies appropriations from which spending to local units of government will occur:

DEPARTMENT OF COMMUNITY HEALTH		
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS		
Community residential and support services	$	387,300
Housing and support services		695,500
Methamphetamine cleanup fund		175,000
Mental health initiatives for older persons		1,049,200
COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS		
State disability assistance program substance abuse services	$	2,509,800
Community substance abuse prevention, education, and treatment programs		19,190,500
Medicaid mental health services		757,907,600
Community mental health non-Medicaid services		317,772,300
Medicaid adult benefits waiver		12,212,000
Multicultural services		5,163,800
Medicaid substance abuse services		15,538,700
Respite services		1,000,000
Children's waiver home care program		2,387,800
Omnibus budget reconciliation act implementation		2,897,400
STATE PSYCHIATRIC HOSPITALS, CENTERS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AND FORENSIC AND PRISON MENTAL HEALTH SERVICES		
Center for forensic psychiatry	$	290,300
PUBLIC HEALTH ADMINISTRATION		
Minority health grants and contracts	$	100,000
Public health administration		76,000
HEALTH POLICY, REGULATION, AND PROFESSIONS		
Health professions	$	99,700
Primary care services		341,900
INFECTIOUS DISEASE CONTROL		
AIDS prevention, testing and care programs	$	742,200
Immunization local agreements		2,132,000
Sexually transmitted disease control local agreements		430,900
LABORATORY SERVICES		
Laboratory services	$	55,400
LOCAL HEALTH ADMINISTRATION AND GRANTS		
Implementation of 1993 PA 133	$	7,700
Local public health operations		35,468,400
CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION		
Cancer prevention and control program	$	137,300
Diabetes and kidney program		370,600
Smoking prevention program		1,014,500
FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES		
Childhood lead program	$	136,500
Dental programs		25,000

Family planning local agreements	$	360,000
Local MCH services		322,200
Pregnancy prevention program		2,300,000
Prenatal care outreach and service delivery support		650,100
School health and education programs		500,000
Special projects		378,900
CHILDREN'S SPECIAL HEALTH CARE SERVICES		
Medical care and treatment	$	528,800
Outreach and advocacy		1,283,200
MEDICAL SERVICES		
Long-term care services	$	81,711,500
Transportation		1,401,300
Medicaid adult benefits waiver		9,573,500
OFFICE OF SERVICES TO THE AGING		
Community services	$	15,054,300
Nutrition services		11,447,300
Foster grandparent volunteer program		791,700
Retired and senior volunteer program		181,300
Senior companion volunteer program		241,400
Respite care program		4,227,400
CRIME VICTIM SERVICES COMMISSION		
Crime victim rights services grants	$	6,446,800
TOTAL OF PAYMENTS TO LOCAL UNITS OF GOVERNMENT	$	1,317,715,000

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

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

Sec. 203. As used in this act:

(a) "AIDS" means acquired immunodeficiency syndrome.

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

(c) "Department" means the Michigan department of community health.

(d) "DSH" means disproportionate share hospital.

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

(f) "FTE" means full-time equated.

(g) "GME" means graduate medical education.

(h) "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.

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

(j) "HMO" means health maintenance organization.

(k) "IDEA" means individuals with disabilities education act.

(*l*) "IDG" means interdepartmental grant.

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

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

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

(p) "Specialty prepaid health plan" means a program described in section 232b of the mental health code, 1974 PA 258, MCL 330.1232b.

(q) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395hhh.

(r) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396v.

(s) "Title XX" means title XX of the social security act, 49 USC 1397 to 1397f.

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

Sec. 204. The department of civil service shall bill the department 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 state classified civil service employees and prohibited from filling any vacant state classified civil service positions. This hiring freeze does not apply to internal transfers of classified employees from 1 position to another within a department.

(2) The state budget director may grant exceptions to this hiring freeze when the state budget director believes that the hiring freeze will 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 quarterly 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 quarter and the reasons to justify the exception.

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

Sec. 209. (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. The director shall take all reasonable steps to ensure businesses in deprived and depressed communities compete for and perform contracts to provide services or supplies, or both. The director shall strongly encourage firms with which the department contracts to subcontract with certified businesses in depressed and deprived communities for services, supplies, or both.

Sec. 211. 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	$	21,162,400
(b) Preventive health and health services block grant		4,534,000
(c) Substance abuse block grant		60,496,600
(d) Healthy Michigan fund		43,551,000
(e) Michigan health initiative		10,335,900

(2) On or before February 1, 2007, 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 2007-2008 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 2007-2008 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 April 1, 2007, 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) Description of allocations or bid processes including need or demand indicators used to determine allocations.

(c) Eligibility criteria for program participation and maximum benefit levels where applicable.

(d) Outcome measures to be used to evaluate programs.

(e) 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, and shall not be used in attempting to influence the decisions of the legislature, the governor, or any state agency.

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

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

(3) The department shall report by March 15, 2007 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 8 conditions listed in section 5431(1)(a) through (h) 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, 2006 and May 1, 2007 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, 2007, 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. 259. From the funds appropriated in part 1 for information technology, departments and agencies shall pay user fees to the department of information technology for technology-related services and projects. Such user fees shall be subject to provisions of an interagency agreement between the departments and agencies and the department of information technology.

Sec. 260. Amounts appropriated in part 1 for information technology may be designated as work projects and carried forward to support technology projects under the direction of the department of information technology. Funds designated in this manner are not available for expenditure until approved as work projects under section 451a of the management and budget act, 1984 PA 431, MCL 18.1451a.

Sec. 261. Funds appropriated in part 1 for the Medicaid management information system upgrade are contingent upon approval of an advanced planning document from the centers for Medicare and Medicaid services. If the necessary matching funds are identified and legislatively transferred to this line item, the corresponding federal Medicaid revenue shall be appropriated at a 90/10 federal/state match rate. This appropriation may be designated as a work project and carried forward to support completion of this project.

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

Sec. 265. The departments and agencies receiving appropriations in part 1 shall receive and retain copies of all reports funded from appropriations in part 1. Federal and state guidelines for short-term and long-term retention of records shall be followed.

Sec. 266. (1) Due to the current budgetary problems in this state, out-of-state travel for the fiscal year ending September 30, 2007 shall be limited to situations in which 1 or more of the following conditions apply:

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

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

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

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

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

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

(2) If out-of-state travel is necessary but does not meet 1 or more of the conditions in subsection (1), the state budget director may grant an exception to allow the travel. Any exceptions granted by the state budget director shall be reported on a monthly basis to the house of representatives and senate standing committees on appropriations.

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

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

(b) The destination of each travel occurrence.

(c) The dates of each travel occurrence.

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

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

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

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

Sec. 269. (1) Of the amount appropriated in part 1 for Medicaid mental health services, $149,136,400.00 is for prepaid inpatient health plan reimbursement of antipsychotic prescriptions under the Medicaid program. All of the following conditions shall apply to this arrangement:

(a) The department shall develop uniform statewide procedures and practices to be followed by the prepaid inpatient health plans. These procedures and practices shall adhere to the requirements of section 1625 and section 109h of the social welfare act, 1939 PA 280, MCL 400.109h.

(b) The department shall include the actual cost of antipsychotic prescriptions, net of actual rebates, into the actuarially sound capitation rates for the prepaid inpatient health plans.

(c) The department shall develop and implement training for prepaid inpatient health programs regarding billing processes required for reimbursement under this section.

(2) Of the amount appropriated in part 1 for health plan services, $86,674,300.00 is for Medicaid health plan reimbursement of antidepressant prescriptions under the Medicaid program. All of the following conditions shall apply to this arrangement:

(a) The department shall develop uniform statewide procedures and practices to be followed by the Medicaid health plans. These procedures shall adhere to the requirements of section 1625 and all provisions of the department's fiscal year 2005-2006 contract with Medicaid health plans.

(b) The department shall include the actual cost of antidepressant prescriptions, net of actual rebates, into the actuarially sound capitation rates for the Medicaid health plans.

(3) Medicaid reimbursement of mental health prescriptions that are neither antipsychotics nor antidepressants shall be made from the medical services pharmaceutical services line in part 1. The department shall utilize the same operational procedures for these medications that were followed in fiscal year 2005-2006 and shall adhere to the requirements of section 109h of the social welfare act, 1939 PA 280, MCL 400.109h.

(4) The directors of the medical services administration and the department's mental health and substance abuse administration shall provide a joint quarterly report to the house of representatives, senate, and the senate and house fiscal agencies on the coordination of psychotropic medications under this section.

Sec. 270. Within 30 days after receipt of the notification from the attorney general's office of a legal action in which expenses had been recovered pursuant to section 106(4) of the social welfare act, 1939 PA 280, MCL 400.106, or any other statute under which the department has the right to recover expenses, the department shall submit a written report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office which includes, at a minimum, all of the following:

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

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

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

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

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. 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. 351. From the funds appropriated in part 1 for the methamphetamine cleanup fund, the department shall allow local governments to apply for money to cover their administrative costs associated with methamphetamine cleanup efforts. The funds allocated to local governments for the administrative costs associated with methamphetamine cleanup efforts shall not exceed $800.00 per property.

COMMUNITY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES PROGRAMS

Sec. 401. Funds appropriated in part 1 are intended to support a system of comprehensive community mental health services under the full authority and responsibility of local CMHSPs or specialty prepaid health plans. The department shall ensure that each CMHSP or specialty prepaid health plan 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 or specialty prepaid health plan'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.

Sec. 402. (1) From funds appropriated in part 1, final authorizations to CMHSPs or specialty prepaid health plans shall be made upon the execution of contracts between the department and CMHSPs or specialty prepaid health plans. The contracts shall contain an approved plan and budget as well as policies and procedures governing the obligations and responsibilities of both parties to the contracts. Each contract with a CMHSP or specialty prepaid health plan that the department is authorized to enter into under this subsection shall include a provision that the contract is not valid unless the total dollar obligation for all of the contracts between the department and the CMHSPs or specialty prepaid health plans entered into under this subsection for fiscal year 2006-2007 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 or specialty prepaid health plans that would affect rates or expenditures are enacted.

(b) Any amendments to contracts with CMHSPs or specialty prepaid health plans 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 or specialty prepaid health plans meet with multicultural service providers to develop a workable framework for contracting, service delivery, and reimbursement.

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 or specialty prepaid health plan and a statewide summary, each of which shall include at least the following information:

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

(b) Per capita expenditures by client population group.

(c) Financial information 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.

(d) 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.

(e) 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.

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

(g) 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.

(h) Lapses and carryforwards during fiscal year 2005-2006 for CMHSPs or specialty prepaid health plans.

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

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

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

(*ii*) Performance indicator information required to be submitted to the department in the contracts with CMHSPs or specialty prepaid health plans.

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

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

Sec. 405. (1) It is the intent of the legislature that the employee wage pass-through funded in previous years 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 settings where skill building, community living supports and training, and personal care services are provided shall continue to be paid to direct care workers.

(2) From the funds appropriated in part 1 for Medicaid mental health services, money shall be utilized to establish a pool of funds available to community mental health services programs, sufficient to provide for increasing the wages and the employer's share of federal insurance contributions act costs of direct care staff by 2% per direct care worker in local residential settings and for paraprofessional and other nonprofessional direct care workers in settings where skill building, community living supports and training, and personal care services are provided, effective October 1, 2006.

(3) Each CMHSP shall make application to the department to receive funds for the direct care worker wage pass-through fund, not to exceed their proportionate share of the money allocated for this purpose. The application shall specify the amount of funds requested and the agencies/programs to receive the wage pass-through funds requested.

(4) Each CMHSP awarded wage pass-through funds shall report on the actual expenditures of such funds in the format to be determined by the department. Any funds not utilized by the CMHSP for the purpose specified in the wage pass-through application shall be deducted from the base allocation to the CMHSP in the subsequent fiscal year.

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 department of human services 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. Coordinating agencies shall work with the CMHSPs or specialty prepaid health plans to coordinate the care and services provided to individuals with both mental illness and substance abuse diagnoses.

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

Sec. 408. (1) By April 15, 2007, the department shall report the following data from fiscal year 2005-2006 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 department of human services 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 or specialty prepaid health plan requires the CMHSP or specialty prepaid health plan 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 or specialty prepaid health plan 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 to provide non-Medicaid substance abuse services at not less than the amount contracted for in fiscal year 2004-2005.

Sec. 414. Medicaid substance abuse treatment services shall be managed by selected CMHSPs or specialty prepaid health plans pursuant to the centers for Medicare and Medicaid services' approval of Michigan's 1915(b) waiver request to implement a managed care plan for specialized substance abuse services. The selected CMHSPs or specialty prepaid health plans 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 or specialty prepaid health plans shall be responsible for the reimbursement of claims for specialized substance abuse services. The CMHSPs or specialty prepaid health plans 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. 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 or specialty prepaid health plans to support the Medicaid managed mental health care program in that month. The information shall include the total paid to each CMHSP or specialty prepaid health plan, per capita rate paid for each eligibility group for each CMHSP or specialty prepaid health plan, and number of cases in each eligibility group for each CMHSP or specialty prepaid health plan, and year-to-date summary of eligibles and expenditures for the Medicaid managed mental health care program.

Sec. 423. (1) The department shall work cooperatively with the departments of human services, 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.

(2) The department shall establish a work group composed of representatives of the department, the departments of human services, corrections, education, state police, and military and veterans affairs, coordinating agencies, CMHSPs, and any other persons considered appropriate to examine and review the source and expenditure of funds for

substance abuse programs and services. The work group shall develop and recommend cost-effective measures for the expenditure of funds and delivery of substance abuse programs and services. The department shall submit the findings of the work group to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by May 31, 2007.

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

(a) A "clean claim" as described in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i, must be paid within 45 days after receipt of the claim by the community mental health services program or specialty prepaid health plan. 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 or specialty prepaid health plan must state in writing to the health professional or facility any defect in the claim within 30 days after receipt of the claim.

(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 or specialty prepaid health plan shall pay the claim within 30 days after the defect is corrected.

Sec. 425. By April 1, 2007, the department, in conjunction with the department of corrections, shall report the following data from fiscal year 2005-2006 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 of the type of substance abuse services provided to prisoners.

(b) The number of prisoners with a primary diagnosis of mental illness and the number of such prisoners receiving mental health services, which shall include a description and breakdown, minimally encompassing the categories of inpatient, residential, and outpatient care, of the type of mental health services provided to those prisoners.

(c) The number of prisoners with a primary diagnosis of mental illness and receiving substance abuse services, which shall include a description and breakdown, minimally encompassing the categories of inpatient, residential, and outpatient care, of the type of treatment provided to those prisoners.

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

(e) Data indicating if prisoners with a primary diagnosis of mental illness and receiving substance abuse services were previously hospitalized in a state psychiatric hospital for persons with mental illness.

Sec. 428. (1) Each CMHSP and affiliation of CMHSPs shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for CMHSPs and affiliations of CMHSPs. 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 or an affiliation of CMHSPs.

(2) The distribution of the aforementioned increases in the capitation payment rates, if any, shall be based on a formula developed by a committee established by the department, including representatives from CMHSPs or affiliations of CMHSPs and department staff.

Sec. 435. A county required under the provisions of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106, to provide matching funds to a CMHSP for mental health services rendered to residents in its jurisdiction shall pay the matching funds in equal installments on not less than a quarterly basis throughout the fiscal year, with the first payment being made by October 1, 2006.

Sec. 442. (1) It is the intent of the legislature that the $40,000,000.00 in funding transferred from the community mental health non-Medicaid services line to support the Medicaid adult benefits waiver program be used to provide state match for increases in federal funding for primary care and specialty services provided to Medicaid adult benefits waiver enrollees and for economic increases for the Medicaid specialty services and supports program.

(2) The department shall assure that persons enrolled in the Medicaid adult benefits waiver program shall receive mental health services under the priority population sections of the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

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

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

Sec. 450. (1) No later than October 1, 2006, the department shall implement the recommendations of the workgroup composed of CMHSPs or specialty prepaid health plans and departmental staff on streamlining the audit and reporting requirements for CMHSPs or specialty prepaid health plans and contractors performing services for CMHSPs or specialty prepaid health plans.

(2) No later than March 31, 2007, the department shall submit a report to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office on steps taken to implement the recommendations of the workgroup and the progress of the implementation of the recommendations of the workgroup.

Sec. 452. Unless otherwise authorized by law, the department shall not implement retroactively any policy that would lead to a negative financial impact on community mental health services programs or prepaid inpatient health plans.

Sec. 456. (1) CMHSPs and prepaid inpatient health plans shall honor consumer choice to the fullest extent possible when providing services and support programs for individuals with mental illness, developmental disabilities, or substance abuse issues. Consumer choices shall include skill-building assistance, rehabilitative and habilitative services, supported and integrated employment services program settings, and other work preparatory services provided in the community or by accredited community-based rehabilitation organizations. CMHSPs and prepaid inpatient health plans shall not arbitrarily eliminate or restrict any choices from the array of services and program settings available to consumers without reasonable justification that those services are not in the consumer's best interest.

(2) CMHSPs and prepaid inpatient health plans shall take all necessary steps to ensure that individuals with mental illness, developmental disabilities, or substance abuse issues be placed in the least restrictive setting in the quickest amount of time possible if it is the individual's choice.

Sec. 458. By April 15, 2007, the department shall provide each of the following to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director:

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

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states.

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

Sec. 459. (1) Any CMHSP located in a county with a population of more than 1,500,000 that is not a community mental health authority pursuant to section 205 of the mental health code, 1974 PA 258, MCL 330.1205, by December 1, 2006 shall have its fiscal year 2006-2007 community mental health non-Medicaid services allotment reduced by $3,500,000.00 each month for the remainder of the fiscal year until that CMHSP becomes an authority.

(2) The reduction in funding to any CMHSP specified in subsection (1) shall not result in any reduction of direct services.

(3) Any county specified in subsection (1) and subject to a funding reduction shall submit a plan to the department regarding these reductions by February 1, 2007. The department shall be responsible for reviewing and approving the plan to ensure that it meets the state legislative letter and intent. The department shall report by March 1, 2007 to the senate and house of representatives appropriations subcommittees on community health, the senate and house of representatives standing committees on health policy, the senate and house fiscal agencies, and the state budget office the department's disposition of the plan and shall provide evidence that the approved plan meets the legislative letter and intent.

(4) If any CMHSP subject to the funding reduction outlined in subsection (1) becomes an authority by September 30, 2007, any reduction in its community mental health non-Medicaid services allotment specified in subsection (1) shall be restored.

Sec. 460. (1) The uniform definitions, standards, and instructions for the classification, allocation, assignment, calculation, recording, and reporting of administrative costs by prepaid inpatient health plans (PIHPs), CMHSPs, and contracted organized provider systems that receive payment or reimbursement from funds appropriated under section 104 of part 1 that are established by the department shall go into effect on October 1, 2006 and shall be fully implemented by September 30, 2007.

(2) No later than October 30, 2006, the department shall provide a copy of the uniform definitions, standards, and instructions to the house of representatives and senate appropriations subcommittees on community health, the house of representatives and senate fiscal agencies, and the state budget director.

(3) The department shall provide the house of representatives and senate appropriations subcommittees on community health, the house of representatives and senate fiscal agencies, and the state budget director with 2 separate progress reports on the implementation required under subsection (1). The progress reports are due on April 1, 2007 and July 1, 2007.

Sec. 462. The department shall establish a workgroup comprised of representatives of the department, CMHSPs, legislature, and any other persons considered appropriate to develop a plan to achieve funding equity for all CMHSPs that receive funds appropriated under the community mental health non-Medicaid services line. The funding equity plan shall establish, at a minimum, a payment schedule or scale to ensure that each CMHSP is paid or reimbursed equally based on the recipient's diagnosis or individual plan of service sufficient to meet his or her needs, or both. The department shall submit the written plan to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by May 31, 2007.

Sec. 463. The department shall establish standard program evaluation measures to assess the overall effectiveness of programs provided through coordinating agencies and service providers in reducing and preventing the incidence of substance abuse. The measures established by the department shall be modeled after the program outcome measures and best practice guidelines for the treatment of substance abuse as proposed by the federal substance abuse and mental health services administration.

Sec. 464. It is the intent of the legislature that revenue received by the department from liquor license fees be expended exclusively to fund programs for the prevention, rehabilitation, care, and treatment of alcoholics pursuant to sections 543(1) and 1115(2) of the Michigan liquor control code of 1998, 1998 PA 58, MCL 436.1543 and 436.2115.

Sec. 465. Funds appropriated in part 1 for respite services shall be used for direct respite care services for children with serious emotional disturbances and their families. Not more than 1% of the funds allocated for respite services shall be expended by CMHSPs for administration and administrative purposes.

Sec. 467. If funds become available, the department shall increase funding paid from the community substance abuse prevention, education, and treatment programs line item to the substance abuse coordinating agencies to the level of funding provided in fiscal year 2002-2003.

Sec. 468. To foster a more efficient administration of and to integrate care in publicly funded mental health and substance abuse services, the department shall recommend changes in its criteria for the incorporation of a city, county, or regional substance abuse coordinating agency into a local community mental health authority that will encourage those city, county, or regional coordinating agencies to incorporate as local community mental health authorities. If necessary, the department may make accommodations or adjustments in formula distribution to address administrative costs related to the recommended changes to the criteria made in accordance with this section and to the incorporation of the additional coordinating agencies into local community mental health authorities provided that all of the following are satisfied:

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

(b) The accommodations or adjustments do not favor coordinating agencies who voluntarily elect to integrate with local community mental health authorities.

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

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

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

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

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

(2) By May 1, 2007, 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 office on the impact and effectiveness of this section and the status of the integration of mental health and substance abuse services.

Sec. 471. From the funds appropriated in part 1 for coordinating agencies and the Salvation Army harbor light program, administrative costs for these agencies as a percentage of their total expenditures shall not exceed their percentage in fiscal year 2004-2005 or 9%, whichever is less.

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

Sec. 475. From the funds appropriated in part 1 for multicultural services, $990,000.00 shall be allocated to the Jewish federation of metropolitan Detroit.

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.

Sec. 602. Unexpended and unencumbered amounts and accompanying expenditure authorizations up to $1,000,000.00 remaining on September 30, 2007 from the amounts appropriated in part 1 for gifts and bequests for patient living and treatment environments shall be carried forward for 1 fiscal year. The purpose of gifts and bequests for patient living and treatment environments is to use additional private funds to provide specific enhancements for individuals residing at state-operated facilities. Use of the gifts and bequests shall be consistent with the stipulation of the donor. The expected completion date for the use of gifts and bequests donations is within 3 years unless otherwise stipulated by the donor.

Sec. 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 or specialty prepaid health plans shall provide annual reports to the department on the following information:

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

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

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

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

(2) The department shall annually report the information in subsection (1) to the house 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 or specialty prepaid health plans 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 on community health and the state budget director.

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

Sec. 606. The department may collect revenue for patient reimbursement from first- and third-party payers, including Medicaid and local county CMHSP payers, to cover the cost of placement in state hospitals and centers. The department is authorized to adjust financing sources for patient reimbursement based on actual revenues earned. If the revenue collected exceeds current year expenditures, the revenue may be carried forward with approval of the state budget director. The revenue carried forward shall be used as a first source of funds in the subsequent year.

PUBLIC HEALTH ADMINISTRATION

Sec. 650. The department shall communicate the annual public health consumption advisory for sportfish. The department shall, at a minimum, post the advisory on the Internet and make the information in the advisory available to the clients of the women, infants, and children special supplemental nutrition program.

Sec. 651. By April 30, 2007, the department shall submit a report to the house and senate fiscal agencies and the state budget director on the activities and efforts of the surgeon general to improve the health status of the citizens of this state with regard to the goals and objectives stated in the "Healthy Michigan 2010" report, and the measurable progress made toward those goals and objectives.

HEALTH POLICY, REGULATION, AND PROFESSIONS

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

Sec. 705. The department shall post on the Internet the executive summary of the latest inspection for each licensed nursing home.

Sec. 706. When hiring any new nursing home inspectors funded through appropriations in part 1, the department shall make every effort to hire individuals with past experience in the long-term care industry.

Sec. 707. The funds appropriated in part 1 for the nurse scholarship program, established in section 16315 of the public health code, 1978 PA 368, MCL 333.16315, shall be used to increase the number of nurses practicing in Michigan. The board of nursing is encouraged to structure scholarships funded under this act in a manner that rewards recipients who intend to practice nursing in Michigan. In addition, the department and the board of nursing shall work cooperatively with the Michigan higher education assistance authority to coordinate scholarship assistance with scholarships provided pursuant to the Michigan nursing scholarship act, 2002 PA 591, MCL 390.1181 to 390.1189.

Sec. 708. Nursing facilities shall report in the quarterly staff report to the department, the total patient care hours provided each month, by state licensure and certification classification, and the percentage of pool staff, by state licensure and certification classification, used each month during the preceding quarter. The department shall make available to the public, the quarterly staff report compiled for all facilities including the total patient care hours and the percentage of pool staff used, by classification.

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

Sec. 710. From the funds appropriated in part 1 for primary care services, an amount not to exceed $1,723,300.00 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. 711. The department may make available to interested entities customized listings of nonconfidential information in its possession, such as names and addresses of licensees. The department may establish and collect a reasonable charge to provide this service. The revenue received from this service shall be used to offset expenses to provide the service. Any balance of this revenue collected and unexpended at the end of the fiscal year shall revert to the appropriate restricted fund.

Sec. 712. From the funds appropriated in part 1 for primary care services, $250,000.00 shall be allocated to free health clinics operating in the state. The department shall distribute the funds equally to each free health clinic. For the purpose of this appropriation, free health clinics are nonprofit organizations that use volunteer health professionals to provide care to uninsured individuals.

Sec. 713. The department is directed to continue support of multicultural agencies that provide primary care services from the funds appropriated in part 1 and to ensure that 100% of these funds are allocated to these agencies in a timely fashion.

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

Sec. 715. The department shall maintain existing contractual and funding arrangements to provide testing, certification, and inspection services for emergency medical service providers through December 31, 2006.

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. If the appropriation in part 1 is not sufficient to maintain the prior year eligibility criteria and drug formulary, the department may revise the eligibility criteria and drug formulary in a manner that is consistent with federal program guidelines.

Sec. 804. The department, in conjunction with efforts to implement the Michigan prisoner reentry initiative, shall cooperate with the department of corrections to share data and information as it relates to prisoners being released and hepatitis C. By April 1, 2007, the department shall report to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on the progress and results of its work and the potential outcomes from its work with the department of corrections under this section.

Sec. 805. The department shall work with health plans, providers, pharmaceutical manufacturers, and other interested parties to ensure that children under the age of 5 receive all of their scheduled vaccinations, including pneumococcal conjugate vaccines to help prevent invasive pneumococcal disease, including meningitis.

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(18) 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, 2006, 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 annually 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 2006-2007 of at least the amount expended in fiscal year 1992-1993 for the services described in subsection (1).

(4) By April 1, 2007, 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. 905. From the funds appropriated in part 1 for local public health operations, $5,150,000.00 shall be used to continue funding hearing and vision screening services through local public health departments. The extent of services provided shall be similar to the extent of services provided in fiscal year 2004-2005.

CHRONIC DISEASE AND INJURY PREVENTION AND HEALTH PROMOTION

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. 1006. (1) 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.

(2) For purposes of complying with 2004 PA 164, $900,000.00 of the funds appropriated in part 1 for the smoking prevention program shall be used for the quit kit program that includes the nicotine patch or nicotine gum.

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 funds appropriated in part 1 for the diabetes and kidney program, $25,000.00 shall be allocated for a diabetes management pilot project in Muskegon County.

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. From the funds appropriated in part 1 for chronic disease prevention, $200,000.00 shall be allocated for osteoporosis prevention and treatment education.

Sec. 1019. From the funds appropriated in part 1 for chronic disease prevention, $50,000.00 may 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. 1028. Contingent on the availability of state-restricted healthy Michigan fund money or federal preventive health and health services block grant fund money, funds may be appropriated for the African-American male health initiative.

Sec. 1029. It is the intent of the legislature that the male participation rate in the African-American male health initiative program be no less than 75%.

FAMILY, MATERNAL, AND CHILDREN'S HEALTH SERVICES

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; 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. 1104. Before April 1, 2007, the department shall submit a report to the house and senate fiscal agencies and the state budget director on planned allocations from the amounts appropriated in part 1 for local MCH services, prenatal care outreach and service delivery support, family planning local agreements, and pregnancy prevention programs. Using applicable federal definitions, the report shall include information on all of the following:

(a) Funding allocations.

(b) Actual number of women, children, and/or adolescents served and amounts expended for each group for the fiscal year 2005-2006.

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 9% 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 December 1 of the current fiscal year, 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, 2006.

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 88% 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 in part 1 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. Service providers receiving funds appropriated in part 1 for family planning local agreements or the pregnancy prevention program shall include an optional response field on general patient information documents requesting information on a patient's marital status.

Sec. 1114. From the funds appropriated in part 1 for special projects, $30,000.00 shall be allocated for creation of an Internet website to inform and train public service and public safety agency personnel regarding the provisions of the safe delivery of newborns law. The website shall be made available to the general public.

Sec. 1129. The department shall provide a report annually 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 number of children with elevated blood lead levels from information available to the department. The report shall provide the information by county, shall include the level of blood lead reported, and shall indicate the sources of the information.

Sec. 1132. From the funds appropriated in part 1 for special projects, $400,000.00 shall be allocated to the nurse family partnership program.

Sec. 1133. The department shall release infant mortality rate data to all local public health departments no later than 48 hours prior to releasing infant mortality rate data to the public.

Sec. 1135. (1) Provision of the school health education 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 health administration in the department of community health.

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

(e) The department of human services.

(f) The department of state police.

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

WOMEN, INFANTS, AND CHILDREN FOOD AND NUTRITION PROGRAM

Sec. 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 based on local commitment of funds.

Sec. 1152. The department shall require that all Medicaid children participating in the special supplemental food program for women, infants, and children receive lead screening testing.

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.

OFFICE OF DRUG CONTROL POLICY

Sec. 1250. The department shall provide $1,800,000.00 in Byrne formula grant program funding to the judiciary by interdepartmental grant.

CRIME VICTIM SERVICES COMMISSION

Sec. 1301. (1) Funds appropriated in part 1 for the crime victim services commission and granted to an organization shall not be used by that organization for lobbying as defined in 1978 PA 472, MCL 4.411 to 4.431, and shall not be used in an attempt to influence the decisions of the legislature, the governor, or any state agency.

(2) The department shall assure that each organization that receives funds appropriated in part 1 for the crime victim services commission to ensure that subsection (1) has not been violated.

Sec. 1302. From the funds appropriated in part 1 for justice assistance grants, up to $50,000.00 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. Unexpended funds shall be carried forward.

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

OFFICE OF SERVICES TO THE AGING

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

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 area agencies and local providers may receive and expend fees for the provision of day care, care management, respite care, and certain eligible home- and community-based services. The fees shall be based on a sliding scale, taking client income into consideration. The fees shall be used to expand services.

Sec. 1406. The appropriation of $5,000,000.00 of merit award trust 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 use of the funds shall be for direct respite care or adult respite care center services. Not more than 9% of the amount allocated under this section shall be expended for administration and administrative purposes.

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 the agencies 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-based services waiver program.

MICHIGAN FIRST HEALTHCARE PLAN

Sec. 1501. Funds appropriated in part 1 for the Michigan first healthcare plan are contingent upon approval of a waiver from the federal government.

Sec. 1502. Upon approval of a waiver from the federal government for the Michigan first healthcare plan, the department shall provide the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director with a report detailing the process that will be utilized to determine which insurance entities will be selected for participation in the Michigan first healthcare plan. The department shall not award a single-source contract to a health plan through the Michigan first healthcare plan.

Sec. 1503. The department shall provide a copy of the federally approved Michigan first healthcare plan or similar proposal to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director at least 90 days before implementing any portion of the Michigan first healthcare plan or other similar proposal.

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 level, pursuant to the state's option to elect such coverage set out at section 1902(a)(10)(A)(*ii*) and (m) of title XIX, 42 USC 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. If an applicant for Medicaid coverage is found to be eligible, the department shall provide payment for all of the Medicaid covered and appropriately authorized services that have been provided to that applicant since the first day of the month in which the applicant filed and the department of human services received the application for Medicaid coverage. Receipt of the application by a local department of human services office is considered the date the application is received. If an application is submitted on the last day of the month and that day falls on a weekend or a holiday and the application is received by the local department of human services office on the first business day following the end of the month, then receipt of the application is considered to have been on the last day of the previous month. As used in this section, "completed application" means an application complete on its face and signed by the applicant regardless of whether the medical documentation required to make an eligibility determination is included.

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 and the state budget director 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 $45.00 per month as an allowable expense against a recipient's income when determining medical services eligibility and patient pay amounts.

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

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

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

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

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

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. 1615. Unless prohibited by federal or state law or regulation, the department shall require enrolled Medicaid providers to submit their billings for services electronically.

Sec. 1620. (1) For fee-for-service recipients who do not reside in nursing homes, the pharmaceutical dispensing fee shall be $2.50 or the pharmacy's usual or customary cash charge, whichever is less. For nursing home residents, the pharmaceutical dispensing fee shall be $2.75 or the pharmacy's usual or customary cash charge, whichever is less.

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

(3) For fee-for-service recipients, an optional mail-order pharmacy program shall be available.

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. 1621a. (1) The department, in conjunction with pharmaceutical manufacturers or their agents, may establish pilot projects to test the efficacy of disease management and health management programs.

(2) The department may negotiate a plan that uses the savings resulting from the services rendered from these programs, in lieu of requiring a supplemental rebate for the inclusion of those participating parties' products on the department's preferred drug list.

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. 1625. The department shall continue its practice of placing all atypical antipsychotic medications on the Medicaid preferred drug list.

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

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

Sec. 1628. (1) The department shall convene by April 2007 a committee to study the implementation of psychotropic pharmacy administration under Medicare part D for individuals dually enrolled in the Medicare and Medicaid programs. This committee shall study and evaluate the effectiveness of mental health consumer enrollment and medication access through the Medicare part D procedures for pharmaceutical management for dual eligibles.

(2) The committee shall include a representative from each of the following organizations: the medical services administration, the office of services to the aging, the department's mental health and substance abuse services division, mental health association of Michigan, national alliance for the mentally ill of Michigan, Michigan psychiatric society, Michigan association of community mental health boards, Michigan pharmacists association, Michigan protection and advocacy service, international association of psychosocial rehabilitation services, and the pharmaceutical industry. The committee shall elect a chairperson who is not employed by state government.

(3) The committee shall produce a report by September 30, 2007 to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies.

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

Sec. 1630. (1) Medicaid coverage for podiatric services, adult dental services, and chiropractic services shall continue at not less than the level in effect on October 1, 2002, except that reasonable utilization limitations may be adopted in order to prevent excess utilization. The department shall not impose utilization restrictions on chiropractic services unless a recipient has exceeded 18 office visits within 1 year.

(2) The department may implement the bulk purchase of hearing aids, impose limitations on binaural hearing aid benefits, and limit the replacement of hearing aids to once every 3 years.

Sec. 1631. (1) 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.

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

(a) Two dollars for a physician office visit.

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

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

(d) One dollar for an outpatient hospital visit.

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

Sec. 1634. 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 and continue the ground mileage reimbursement rate per statute mile at $4.25.

Sec. 1635. From the funds appropriated in part 1 for physician services and health plan services, the department shall continue the increase in Medicaid reimbursement rates for obstetrical services implemented in fiscal year 2005-2006.

Sec. 1636. (1) From the funds appropriated in part 1 for physician services and health plan services, $16,623,600.00, of which $7,251,200.00 is general fund/general purpose funds, shall be allocated to increase Medicaid reimbursement rates for physician well child procedure codes and primary care procedure codes. The increased reimbursement rates in this section shall be implemented October 1, 2006 and shall not exceed the comparable Medicare payment rate for the same services.

(2) By October 1, 2006, the department shall provide a report to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies that identifies the specific procedure codes affected by this provision as well as the amount and percentage increase provided for each procedure code.

Sec. 1637. (1) All adult Medicaid recipients shall be offered the opportunity to sign a Medicaid personal responsibility agreement.

(2) The personal responsibility agreement shall include at minimum the following provisions:

(a) That the recipient shall not smoke.

(b) That the recipient shall attend all scheduled medical appointments.

(c) That the recipient shall exercise regularly.

(d) That if the recipient has children, those children shall be up to date on their immunizations.

(e) That the recipient shall abstain from abusing controlled substances and narcotics.

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. 1643. Of the funds appropriated in part 1 for graduate medical education in the hospital services and therapy line-item appropriation, not less than $10,359,000.00 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 if the necessary allowable Medicaid matching funds are provided by the universities.

Sec. 1647. From the funds appropriated in part 1 for medical services, the department shall allocate for graduate medical education not less than the level of rates and payments in effect on April 1, 2005.

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 continue breast and cervical cancer treatment coverage for women up to 250% of the federal poverty level, who are under age 65, and who are not otherwise covered by insurance. This coverage shall be provided to women who have been screened through the centers for disease control 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, 114 Stat. 1381.

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 CFR part 418.

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

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

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

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

(d) Enrollment of recipients of children's special health care services in HMOs shall be voluntary during the fiscal year.

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

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

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

Sec. 1656. (1) The department shall provide an expedited complaint review procedure for Medicaid 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, and the state budget office.

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.

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

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

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

Sec. 1659. The following sections of this act are the only ones that shall apply to the following Medicaid managed care programs, including the comprehensive plan, children's special health care services plan, MIChoice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 401, 402, 404, 411, 414, 418, 424, 428, 456, 1650, 1651, 1653, 1654, 1655, 1656, 1657, 1658, 1660, 1661, 1662, 1666, 1699, 1711, 1749, 1752, 1753, and 1766.

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 Medicaid HMOs and local health departments to improve performance on measures related to the care of children and pregnant women.

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

(2) The department shall 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 assure that training and technical assistance are available for EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

Sec. 1666. To increase timely repayment of the maternity case rate to health plans and reduce the need to recover revenue from hospitals, the department shall implement system changes to assure that children who are born to mothers who are Medicaid eligible and enrolled in health plans are within 30 days after birth included in the Medicaid eligibility file and enrolled in the same health plan as the mother or any other health plan designated by the mother.

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 may provide up to 1 year of continuous eligibility to children eligible for the MIChild program unless the family fails to pay the monthly premium, a child reaches age 19, or the status of the children's family changes and its members no longer meet the eligibility criteria as specified in the federally approved MIChild state plan.

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

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

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

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

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

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

(7) The department may make payments on behalf of children enrolled in the MIChild program from the line-item appropriation associated with the program as described in the MIChild state plan approved by the United States department of health and human services, or from other medical services 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. 1673. (1) 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 be less than $10.00 or exceed $15.00 for a family.

(2) The department shall not require copayments under the MIChild program.

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. 1680. (1) Payment increases for enhanced wages and new or enhanced employee benefits provided in previous years through the Medicaid nursing home wage pass-through program shall be continued in fiscal year 2006-2007.

(2) The department shall not implement any increase or decrease in the Medicaid nursing home wage pass-through program in fiscal year 2005-2006.

Sec. 1681. From the funds appropriated in part 1 for home- and community-based services, the department and local waiver agents shall encourage the use of family members, friends, and neighbors of home- and community-based services participants, where appropriate, to provide homemaker services, meal preparation, transportation, chore services, and other nonmedical covered services to participants in the Medicaid home- and community-based services program. This section shall not be construed as allowing for the payment of family members, friends, or neighbors for these services unless explicitly provided for in federal or state law.

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

(2) 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. (1) Of the funds appropriated in part 1 for the Medicaid home- and community-based services waiver program, the payment rate allocated for administrative expenses for fiscal year 2006-2007 shall continue at the rate implemented in fiscal year 2005-2006 after the $2.00 per person per day mandated reduction.

(2) The savings realized from continuing the reduced administrative rate shall be reallocated to increase enrollment in the waiver program and to provide direct services to eligible program participants.

(3) The department shall provide a report by April 1, 2007, to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the number of nursing home patients discharged who are subsequently enrolled in the Medicaid home- and community-based services waiver program, and the associated cost savings.

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) The department shall submit a report by April 30, 2007 to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the progress of 4 Medicaid long-term care single point of entry services pilot projects. The department shall also submit a final plan to the house of representatives and senate subcommittees on community health and the house and senate fiscal agencies 60 days prior to any expansion of the program.

(2) In addition to the report required under subsection (1), the department shall report all of the following to the house of representatives and senate appropriations subcommittees on community health and the house of representatives and senate fiscal agencies by September 30, 2007:

(a) The total cost of the single point of entry program.

(b) The total cost of each designated single point of entry.

(c) The total amount of Medicaid dollars saved because of the program.

(d) The total number of emergent single point of entry cases handled and the average length of time for placement in long-term care for those cases.

(e) The total number of single point of entry cases involving transfer from hospital settings to long-term care settings and the average length of time for placement of those cases in long-term care settings.

(3) It is the intent of the legislature that funding for single point of entry for long-term care end on September 30, 2008.

(4) As used in this section, "single point of entry" means a system that enables consumers to access Medicaid long-term care services and supports through 1 agency or organization and that promotes consumer education and choice of long-term care options.

Sec. 1687. (1) From the funds appropriated in part 1 for long-term care services, the department shall contract with a stand-alone psychiatric facility that provides at least 20% of its total care to Medicaid recipients to provide access to Medicaid recipients who require specialized Alzheimer's disease or dementia care.

(2) The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the effectiveness of the contract required under subsection (1) to improve the quality of services to Medicaid recipients.

Sec. 1688. 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 services 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 services waiver is not a violation of this section.

Sec. 1689. (1) Priority in enrolling additional persons in the Medicaid home- and community-based services waiver program shall be given to those who are currently residing in nursing homes or who are eligible to be admitted to a nursing home if they are not provided home- and community-based services. The department shall implement screening and assessment procedures to assure that no additional Medicaid eligible persons are admitted to nursing homes who would be more appropriately served by the Medicaid home- and community-based services waiver program. If there is a net decrease in the number of Medicaid nursing home days of care during the most recent quarter in comparison with the previous quarter and a net cost savings attributable to moving individuals from a nursing home to the home- and community-based services waiver program, the department shall transfer the net cost savings to the home- and community-based services waiver program. If a transfer is required, it shall be done on a quarterly basis.

(2) Within 30 days of the end of each fiscal quarter, the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies that details existing and future allocations for the home- and community-based services waiver program by regions as well as the associated expenditures. The report shall include information regarding the net cost savings from moving individuals from a nursing home to the home- and community-based services waiver program and the amount of funds transferred.

Sec. 1691. The funding increase of $31,462,600.00 provided in part 1 for the adult home help program shall be passed through to adult home help workers subject to the following conditions:

(a) All adult home help workers providing care under the adult home help program shall receive a wage of at least $7.00 per hour, effective October 1, 2006.

(b) Adult home help workers employed by a county which paid those adult home help workers at least $7.00 per hour as of July 1, 2006 shall receive a wage rate increase of $0.50 per hour.

(c) The department, in conjunction with the department of human services, shall revise any policies, rules, procedures, or regulations that may be an administrative barrier to the implementation of the wage increases described in this section.

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

Sec. 1694. 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. 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. 1699. The department may make separate payments directly to qualifying hospitals serving a disproportionate share of indigent patients in the amount of $50,000,000.00, 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. 1701. The department shall make available to Medicaid providers and HMOs an online resource that will list enrollment and benefits information for each Medicaid recipient. This resource shall be made available to providers and HMOs at no charge.

Sec. 1710. Any proposed changes by the department to the MIChoice home- and community-based services waiver program screening process shall be provided to the members of the house and senate appropriations subcommittees on community health prior to implementation of the proposed changes.

Sec. 1711. (1) The department shall maintain the 2-tier reimbursement methodology for Medicaid emergency physicians professional services that was in effect on September 30, 2002, subject to the following conditions:

(a) Payments by case and in the aggregate shall not exceed 70% of Medicare payment rates.

(b) Total expenditures for these services shall not exceed the level of total payments made during fiscal year 2001-2002, after adjusting for Medicare copayments and deductibles and for changes in utilization.

(2) To ensure that total expenditures stay within the spending constraints of subsection (1)(b), the department shall develop a utilization adjustor for the basic 2-tier payment methodology. The adjustor shall be based on a good faith estimate by the department as to what the expected utilization of emergency room services will be during fiscal year 2006-2007, given changes in the number and category of Medicaid recipients. If expenditure and utilization data indicate that the amount and/or type of emergency physician professional services are exceeding the department's estimate, the utilization adjustor shall be applied to the 2-tier reimbursement methodology in such a manner as to reduce aggregate expenditures to the fiscal year 2001-2002 adjusted expenditure target.

(3) The department shall encourage each Medicaid HMO to create a criteria-based emergency room observation rate for Medicaid eligibles with a length of stay of not more than 24 hours.

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

(2) Except as otherwise specified in this section, "rural" means a county, city, village, or township with a population of not more than 30,000, including those entities if located within a metropolitan statistical area.

Sec. 1713. (1) The department, in conjunction with the Michigan dental association, shall undertake a study to determine the level of participation by Michigan licensed dentists in the state's Medicaid program. The study shall identify the distribution of dentists throughout the state, the volume of Medicaid recipients served by each participating dentist, and areas in the state underserved for dental services.

(2) The study described in subsection (1) shall also include an assessment of what factors may be related to the apparent low participation by dentists in the Medicaid program, and the study shall make recommendations as to how these barriers to participation may be reduced or eliminated.

(3) This study shall be provided to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies no later than April 1, 2007.

Sec. 1716. The department shall seek to maintain a constant enrollment level within the Medicaid adult benefits waiver program throughout fiscal year 2006-2007.

Sec. 1717. (1) The department shall create 2 pools for distribution of disproportionate share hospital funding. The first pool, totaling $45,000,000.00, shall be distributed using the distribution methodology used in fiscal year 2003-2004. The second pool, totaling $5,000,000.00, shall be distributed to unaffiliated hospitals and hospital systems that received less than $900,000.00 in disproportionate share hospital payments in fiscal year 2003-2004 based on a formula that is weighted proportional to the product of each eligible system's Medicaid revenue and each eligible system's Medicaid utilization.

(2) By September 30, 2007, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the new distribution of funding to each eligible hospital from the 2 pools.

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

Sec. 1720. The department shall continue its Medicare recovery program.

Sec. 1721. The department shall conduct a review of Medicaid eligibility pertaining to funds prepaid to a nursing home or other health care facility that are subsequently returned to an individual who becomes Medicaid eligible and shall report its findings to the members of the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies not later than May 15, 2007. Included in its report shall be recommendations for policy and procedure changes regarding whether any funds prepaid to a nursing home or other health care facility that

are subsequently returned to an individual, after the date of Medicaid eligibility and patient pay amount determination, shall be considered as a countable asset and recommendations for a mechanism for departmental monitoring of those funds.

Sec. 1722. (1) From the funds appropriated in part 1 for special Medicaid reimbursement payments, the department is authorized to make a disproportionate share payment of $33,167,700.00 for health services provided by Hutzel Hospital.

(2) The funding authorized under subsection (1) shall only be expended if the necessary Medicaid matching funds are provided by, or on behalf of, the hospital as allowable state match.

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

Sec. 1725. The department shall continue to work with the department of human services to reduce Medicaid eligibility errors related to basic eligibility requirements and income requirements.

Sec. 1726. Any clinical laboratory performing a creatinine test on a Medicaid client shall report the glomerular filtration rate (eGFR) of the patient and shall report it as a percent of kidney function remaining.

Sec. 1728. The department shall make available to qualifying Medicaid recipients, not based on Medicare guidelines, freestanding, electric, lifting, and transferring devices.

Sec. 1731. (1) Subject to subsection (2), the department shall continue an asset test to determine Medicaid eligibility for individuals who are parents, caretaker relatives, or individuals between the ages of 18 and 21 and who are not required to be covered under federal Medicaid requirements.

(2) Regardless of the results of the asset test established under subsection (1), an individual who is between the ages of 18 and 21 and is not required to be covered under the federal Medicaid requirements is not eligible for the state Medicaid program if his or her parent, parents, or legal guardian has health care coverage for him or her or has access to health care coverage for him or her.

Sec. 1732. The department shall assure that, if proposed modifications to the quality assurance assessment program for nursing homes are not implemented, the projected general fund/general purpose savings shall not be achieved through reductions in nursing home reimbursement rates.

Sec. 1733. The department shall seek additional federal funds to permit the state to provide financial support for electronic prescribing and other health information technology initiatives.

Sec. 1734. The department shall seek federal funds that will permit the state to provide financial incentives for positive health behavior practiced by Medicaid recipients. The structure of this incentive program may be similar to programs in other states that authorize monetary rewards to be deposited in individual accounts for Medicaid recipients who demonstrate positive changes in health behavior.

Sec. 1735. (1) The department shall establish a committee that will attempt to identify possible Medicaid program savings associated with the creation of a preferred provider program or an alternative program for durable medical equipment, prosthetics, and orthotics.

(2) To assure quality and access, the preferred provider program shall involve providers who can offer a broad statewide network of services and who are accredited by the joint commission on accreditation of health care organizations or the accreditation commission for health care, inc. and the American board for certification in orthotics and prosthetics.

(3) This committee shall include, at minimum, representatives from each of the contracted Medicaid HMOs, the medical services administration, the Michigan state medical society, the Michigan osteopathic society, the Michigan home health association, the Michigan health and hospital association, and 2 accredited providers.

(4) By April 1, 2007, the committee shall report to the senate and house of representatives subcommittees on community health, the state budget director, and the department on possible durable medical equipment contracting opportunities and anticipated Medicaid program savings.

Sec. 1738. (1) The department shall explore ways to increase the federal disproportionate share hospital cap.

(2) If the disproportionate share hospital cap is increased, the department shall consider increasing funding for county health plans and shall consider disproportionate share hospital payments to trauma centers.

Sec. 1739. The department shall determine the 10 most prevalent and costly ailments affecting Medicaid recipients and shall establish medical outcome targets for each of those ailments. The department may use indicators that recipients are successfully managing chronic disease, measures of recipient compliance with treatment plans, and studies of the proportion of Medicaid providers who follow established best practices in treating chronic disease as possible medical outcome measures. The department shall make bonus payments available to Medicaid HMOs that meet these outcome targets.

Sec. 1740. From the funds appropriated in part 1 for health plan services, the department shall assure that all GME funds are promptly distributed to qualifying hospitals using a methodology developed in consultation with the graduate medical education advisory group. The advisory group shall include representatives of the Michigan health and hospital association and Michigan association of health plans. If the department and the advisory group are unable to reach a consensus on the distribution methodology, the department shall initiate a legislative transfer to transfer the GME funds from health plan services to hospital services and therapy and distribute the GME funds using the mechanism in place for fiscal year 2005-2006.

Sec. 1741. The department shall continue to provide nursing homes the opportunity to receive interim payments upon their request. The department shall make efforts to ensure that the interim payments are as similar to expected cost-settled payments as possible.

Sec. 1742. The department shall allow the retention of $1,000,000.00 in special Medicaid reimbursement funding by any public hospital that meets each of the following criteria:

(a) The hospital participates in the intergovernmental transfers.

(b) The hospital is not affiliated with a university.

(c) The hospital provides surgical services.

(d) The hospital has at least 10,000 Medicaid bed days.

Sec. 1746. Beginning October 1, 2006, the department shall increase the monthly Medicaid personal care supplement by $10.00 to adult foster care facilities and homes for the aged providing personal care services to Medicaid beneficiaries.

Sec. 1747. In order to be reimbursed for adult home help services provided to Medicaid recipients, the matching of adult home help providers with service recipients shall be coordinated by the local county department of human services.

Sec. 1749. Effective September 30, 2007, the department shall require all Medicaid health plans to use the same standard billing formats.

Sec. 1751. The department shall provide a report by April 1, 2007, to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on establishing Medicaid diagnosis related group rates based on fee-for-service and health plan costs.

Sec. 1752. The department shall provide a Medicaid health plan with any information that may assist the Medicaid health plan in determining whether another party may be responsible, in whole or in part, for the payment of health benefits.

Sec. 1753. The department shall take steps to obtain data from auto insurers on insurance payouts for health care claims. If the auto insurers do not voluntarily release the information upon request, the department shall propose legislation to require those insurers to disclose that information upon request. The department shall provide the information received under this section to Medicaid health plans.

Sec. 1756. Not later than March 1, 2007, the department shall establish and implement a specialized case management program to serve the most costly Medicaid beneficiaries who are not enrolled in a health plan and are noncompliant with medical management, including persons with chronic diseases and mental health diagnoses, high prescription drug utilizers, members demonstrating noncompliance with previous medical management, and neonates. The case management program shall, at a minimum, provide a performance payment incentive for physicians who manage the recipient's care and health costs in the most effective way. The department may also develop additional

contractual arrangements with 1 or more Medicaid HMOs for the provision of specialized case management services. Contracts with Medicaid HMOs may include provisions requiring collection of data related to Medicaid recipient compliance. Measures of patient compliance may include the proportion of clients who fill their prescriptions, the rate of clients who do not show for scheduled medical appointments, and the proportion of clients who use their medication.

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

Sec. 1758. The department shall submit a report on the number of individuals who receive the emergency services only Medicaid benefit and the annual amount of Medicaid expenditures for this population to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies by April 1, 2007.

Sec. 1759. The department shall implement the following policy changes included in the federal deficit reduction act of 2005, Public Law 109-171:

(a) Lengthening the look back policy for asset transfers from 3 to 5 years.

(b) Changing the penalty period to begin the day an individual applies for Medicaid.

(c) Individuals with more than $500,000.00 in home equity do not qualify for Medicaid.

(d) Utilize the Medicaid false claim act, 1977 PA 72, MCL 400.601 to 400.613, to collect an enhanced state share of damages collected from entities that have been successfully prosecuted for filing a fraudulent Medicaid claim.

Sec. 1760. (1) In addition to the funds appropriated in part 1 for the health information technology initiatives, the department shall seek out and apply for federal and private grant funding for health information technology efforts.

(2) The department shall apply for Medicaid transformation grant funds made available in the federal deficit reduction act of 2005, Public Law 109-171, to support health information technology efforts.

Sec. 1761. (1) The department shall distribute all funds recovered by the medical services administration from prior and future Medicaid access to care initiative payments exceeding the hospital upper payment limit for inpatient and outpatient services to hospitals meeting any of the following characteristics:

(a) Is located in a rural county as determined by the most recent United States census or is located in a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 110,000 as of the official federal 2000 decennial census.

(b) Is a Medicare sole community hospital.

(c) Is a Medicare dependent hospital and rural referral center hospital.

(2) The distribution under subsection (1) shall be based upon each hospital's Medicaid fee-for-service and HMO payments as developed in consultation with rural hospitals and the Michigan health and hospital association.

Sec. 1762. In order to save money, the department shall adopt an Internet-based workflow management tool to streamline administrative functions such as prior authorizations, provider correspondence, provider enrollment, third-party recovery, level of care determinations, claims processing, and provider, interdepartmental, and contractor communication.

Sec. 1763. From the funds appropriated in part 1 for health information technology initiatives, the department shall participate in a pilot project related to the electronic exchange of health information in southeast Michigan and make these funds available through a competitive bid process.

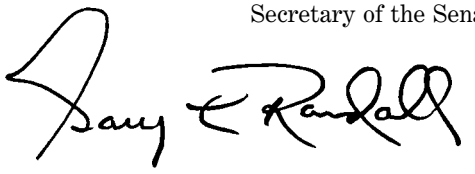
Sec. 1764. The department will annually certify rates paid to Medicaid health plans as being actuarially sound in accordance with federal requirements and will provide a copy of the rate certification and approval immediately to the house of representatives and senate appropriations subcommittees on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

Sec. 1767. The department shall study and evaluate the impact of the change in the way in which the Medicaid program pays pharmacists for prescriptions from average wholesale price to average manufacturer price as required by the federal deficit reduction act of 2005, Public Law 109-171. By March 1, 2007, the department shall submit a report of its study to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies. If the department finds that there is a negative impact on the pharmacists, the department shall reexamine the current pharmaceutical dispensing fee structure established under section 1620 and include in the report recommendations and proposals to counter the negative impact of that federal legislation.

This act is ordered to take immediate effect.

Carol Morey Viventi

Secretary of the Senate



Clerk of the House of Representatives

Approved _____

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Governor