SENATE SUBSTITUTE FOR

HOUSE BILL NO. 4714

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

by amending sections 105, 105a, 106, 107, 108, and 109c (MCL 400.105, 400.105a, 400.106, 400.107, 400.108, and 400.109c), section 105 as amended by 1980 PA 321, section 105a as added by 1988 PA 438, sections 106 and 107 as amended by 2006 PA 144, and section 109c as amended by 1994 PA 302, and by adding sections 105c, 105d, 105e, and 105f.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 105. (1) The ~~state~~ department **OF COMMUNITY HEALTH** shall
2 establish a program for medical assistance for the medically
3 indigent under title XIX. The director of the ~~state~~ department **OF**
4 **COMMUNITY HEALTH** shall administer the program established by the
5 ~~state~~ department **OF COMMUNITY HEALTH** and shall be responsible for

1 determining eligibility under this act. Except as otherwise
2 provided in this act, the director may delegate the authority to
3 perform a function necessary or appropriate for the proper
4 administration of the program.
5 (2) As used in this section and sections 106 to 112, "peer
6 review advisory committee" means an entity comprising professionals
7 and experts who are selected by the director and nominated by an
8 organization or association or organizations or associations
9 representing a class of providers.
10 (3) As used in sections 106 to 112, "professionally accepted
11 standards" means those standards developed by peer review advisory
12 committees and professionals and experts with whom the director is
13 required to consult.
14 (4) As used in this section and sections 106 to 112,
15 "provider" means an individual, sole proprietorship, partnership,
16 association, corporation, institution, agency, or other legal
17 entity, who has entered into an agreement of enrollment specified
18 by the director ~~pursuant to~~ **UNDER** section ~~111b(1)(c).~~**111B(4).**
19 Sec. 105a. (1) The department **OF COMMUNITY HEALTH** shall
20 develop written information that sets forth the eligibility
21 requirements for participation in the program of medical assistance
22 administered under this act. The written information shall be
23 updated not less than every 2 years.
24 (2) The department **OF COMMUNITY HEALTH** shall provide copies of
25 the written information described in subsection (1) to all of the
26 following persons, agencies, and health facilities:
27 (a) A person applying to the department **OF COMMUNITY HEALTH**

1 for participation in the program of medical assistance administered
2 under this act who is considering institutionalization for the
3 person or person's family member in a nursing home or home for the
4 aged.

5 (b) Each nursing home in the state.

6 (c) Each hospital in the state.

7 (d) Each adult foster care facility in the state.

8 (e) Each area agency on aging.

9 (f) The office of services to the aging.

10 (g) Local health departments.

11 (h) Community mental health boards.

12 (i) Medicaid and medicare certified home health agencies.

13 (j) County medical care facilities.

14 (k) Appropriate department of ~~social services~~ **COMMUNITY HEALTH**
15 personnel.

16 (*l*) Any other person, agency, or health facility determined to
17 be appropriate by the department **OF COMMUNITY HEALTH**.

18 **SEC. 105C. THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH**
19 **SHALL SUBMIT A RECOMMENDATION TO THE SENATE MAJORITY LEADER, THE**
20 **SPEAKER OF THE HOUSE, AND THE STATE BUDGET OFFICE ON HOW TO MOST**
21 **EFFECTIVELY DETERMINE MEDICAID ELIGIBILITY AND ENROLLMENT FOR ALL**
22 **APPLICANTS BY JANUARY 1, 2015. THE DEPARTMENT OF COMMUNITY HEALTH**
23 **MAY DELEGATE THIS FUNCTION TO ANOTHER STATE AGENCY, PERFORM THE**
24 **FUNCTION DIRECTLY, OR CONTRACT WITH A PRIVATE OR NONPROFIT ENTITY,**
25 **CONSISTENT WITH STATE LAW.**

26 **SEC. 105D. (1) THE DEPARTMENT OF COMMUNITY HEALTH SHALL SEEK A**
27 **WAIVER FROM THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN**

1 SERVICES TO DO, WITHOUT JEOPARDIZING FEDERAL MATCH DOLLARS OR
2 OTHERWISE INCURRING FEDERAL FINANCIAL PENALTIES, AND UPON APPROVAL
3 OF THE WAIVER SHALL DO, ALL OF THE FOLLOWING:
4 (A) ENROLL INDIVIDUALS ELIGIBLE UNDER SECTION
5 1396A(A)(10)(A)(I)(VIII) OF TITLE XIX WHO MEET THE CITIZENSHIP
6 PROVISIONS OF 42 CFR 435.406 AND WHO ARE OTHERWISE ELIGIBLE FOR THE
7 MEDICAL ASSISTANCE PROGRAM UNDER THIS ACT INTO A CONTRACTED HEALTH
8 PLAN THAT PROVIDES FOR AN ACCOUNT INTO WHICH MONEY FROM ANY SOURCE,
9 INCLUDING, BUT NOT LIMITED TO, THE ENROLLEE, THE ENROLLEE'S
10 EMPLOYER, AND PRIVATE OR PUBLIC ENTITIES ON THE ENROLLEE'S BEHALF,
11 CAN BE DEPOSITED TO PAY FOR INCURRED HEALTH EXPENSES, INCLUDING,
12 BUT NOT LIMITED TO, CO-PAYS. THE ACCOUNT SHALL BE ADMINISTERED BY
13 THE DEPARTMENT OF COMMUNITY HEALTH AND CAN BE DELEGATED TO A
14 CONTRACTED HEALTH PLAN OR A THIRD PARTY ADMINISTRATOR, AS
15 CONSIDERED NECESSARY. THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT
16 BEGIN ENROLLMENT OF INDIVIDUALS ELIGIBLE UNDER THIS SUBDIVISION
17 UNTIL JANUARY 1, 2014 OR UNTIL THE WAIVER REQUESTED IN THIS
18 SUBSECTION IS APPROVED BY THE UNITED STATES DEPARTMENT OF HEALTH
19 AND HUMAN SERVICES, WHICHEVER IS LATER.
20 (B) ENSURE THAT CONTRACTED HEALTH PLANS TRACK ALL ENROLLEE CO-
21 PAYS INCURRED FOR THE FIRST 6 MONTHS THAT AN INDIVIDUAL IS ENROLLED
22 IN THE PROGRAM DESCRIBED IN SUBDIVISION (A) AND CALCULATE THE
23 AVERAGE MONTHLY CO-PAY EXPERIENCE FOR THE ENROLLEE. THE AVERAGE CO-
24 PAY AMOUNT SHALL BE ADJUSTED AT LEAST ANNUALLY TO REFLECT CHANGES
25 IN THE ENROLLEE'S CO-PAY EXPERIENCE. THE DEPARTMENT OF COMMUNITY
26 HEALTH SHALL ENSURE THAT EACH ENROLLEE RECEIVES QUARTERLY
27 STATEMENTS FOR HIS OR HER ACCOUNT THAT INCLUDE EXPENDITURES FROM

1 THE ACCOUNT, ACCOUNT BALANCE, AND THE COST-SHARING AMOUNT DUE FOR
2 THE FOLLOWING 3 MONTHS. THE ENROLLEE SHALL BE REQUIRED TO REMIT
3 EACH MONTH THE AVERAGE CO-PAY AMOUNT CALCULATED BY THE CONTRACTED
4 HEALTH PLAN INTO THE ENROLLEE'S ACCOUNT. THE DEPARTMENT OF
5 COMMUNITY HEALTH SHALL PURSUE A RANGE OF CONSEQUENCES FOR ENROLLEES
6 WHO CONSISTENTLY FAIL TO MEET THEIR COST-SHARING REQUIREMENTS,
7 INCLUDING, BUT NOT LIMITED TO, USING THE MICHILD PROGRAM AS A
8 TEMPLATE AND CLOSER OVERSIGHT BY HEALTH PLANS IN ACCESS TO
9 PROVIDERS. THE DEPARTMENT OF COMMUNITY HEALTH SHALL REPORT ITS PLAN
10 OF ACTION FOR ENROLLEES WHO CONSISTENTLY FAIL TO MEET THEIR COST-
11 SHARING REQUIREMENTS TO THE LEGISLATURE BY JUNE 1, 2014.
12 (C) GIVE ENROLLEES DESCRIBED IN SUBDIVISION (A) A CHOICE IN
13 CHOOSING AMONG CONTRACTED HEALTH PLANS.
14 (D) ENSURE THAT ALL ENROLLEES DESCRIBED IN SUBDIVISION (A)
15 HAVE ACCESS TO A PRIMARY CARE PRACTITIONER WHO IS LICENSED,
16 REGISTERED, OR OTHERWISE AUTHORIZED TO ENGAGE IN HIS OR HER HEALTH
17 CARE PROFESSION IN THIS STATE AND TO PREVENTIVE SERVICES. THE
18 DEPARTMENT OF COMMUNITY HEALTH SHALL REQUIRE THAT ALL NEW ENROLLEES
19 BE ASSIGNED AND HAVE SCHEDULED AN INITIAL APPOINTMENT WITH THEIR
20 PRIMARY CARE PRACTITIONER WITHIN 60 DAYS OF INITIAL ENROLLMENT. THE
21 DEPARTMENT OF COMMUNITY HEALTH SHALL MONITOR AND TRACK CONTRACTED
22 HEALTH PLANS FOR COMPLIANCE IN THIS AREA AND CONSIDER THAT
23 COMPLIANCE IN ANY HEALTH PLAN INCENTIVE PROGRAMS. THE DEPARTMENT OF
24 COMMUNITY HEALTH SHALL ENSURE THAT THE CONTRACTED HEALTH PLANS HAVE
25 PROCEDURES TO ENSURE THAT THE PRIVACY OF THE ENROLLEES' PERSONAL
26 INFORMATION IS PROTECTED IN ACCORDANCE WITH THE HEALTH INSURANCE
27 PORTABILITY AND ACCOUNTABILITY ACT OF 1996, PUBLIC LAW 104-191.

1 (E) REQUIRE ENROLLEES DESCRIBED IN SUBDIVISION (A) WITH ANNUAL
2 INCOMES BETWEEN 100% AND 133% OF THE FEDERAL POVERTY GUIDELINES TO
3 CONTRIBUTE NOT MORE THAN 5% OF INCOME ANNUALLY FOR COST-SHARING
4 REQUIREMENTS. COST-SHARING INCLUDES CO-PAYS AND REQUIRED
5 CONTRIBUTIONS MADE INTO THE ACCOUNTS AUTHORIZED UNDER SUBDIVISION
6 (A). CONTRIBUTIONS REQUIRED IN THIS SUBDIVISION DO NOT APPLY FOR
7 THE FIRST 6 MONTHS AN INDIVIDUAL DESCRIBED IN SUBDIVISION (A) IS
8 ENROLLED. REQUIRED CONTRIBUTIONS TO AN ACCOUNT USED TO PAY FOR
9 INCURRED HEALTH EXPENSES SHALL BE 2% OF INCOME ANNUALLY.
10 NOTWITHSTANDING THIS MINIMUM, REQUIRED CONTRIBUTIONS MAY BE REDUCED
11 BY THE CONTRACTING HEALTH PLAN. THE REDUCTIONS MAY OCCUR ONLY IF
12 HEALTHY BEHAVIORS ARE BEING ADDRESSED AS ATTESTED TO BY THE
13 CONTRACTED HEALTH PLAN BASED ON UNIFORM STANDARDS DEVELOPED BY THE
14 DEPARTMENT OF COMMUNITY HEALTH IN CONSULTATION WITH THE CONTRACTED
15 HEALTH PLANS. THE UNIFORM STANDARDS SHALL INCLUDE HEALTHY BEHAVIORS
16 THAT MUST INCLUDE, BUT ARE NOT LIMITED TO, COMPLETING A DEPARTMENT
17 OF COMMUNITY HEALTH APPROVED ANNUAL HEALTH RISK ASSESSMENT TO
18 IDENTIFY UNHEALTHY CHARACTERISTICS, INCLUDING ALCOHOL USE,
19 SUBSTANCE USE DISORDERS, TOBACCO USE, OBESITY, AND IMMUNIZATION
20 STATUS. CO-PAYS CAN BE REDUCED IF HEALTHY BEHAVIORS ARE MET, BUT
21 NOT UNTIL ANNUAL ACCUMULATED CO-PAYS REACH 2% OF INCOME EXCEPT CO-
22 PAYS FOR SPECIFIC SERVICES MAY BE WAIVED BY THE CONTRACTED HEALTH
23 PLAN IF THE DESIRED OUTCOME IS TO PROMOTE GREATER ACCESS TO
24 SERVICES THAT PREVENT THE PROGRESSION OF AND COMPLICATIONS RELATED
25 TO CHRONIC DISEASES. IF THE ENROLLEE DESCRIBED IN SUBDIVISION (A)
26 BECOMES INELIGIBLE FOR MEDICAL ASSISTANCE UNDER THE PROGRAM
27 DESCRIBED IN THIS SECTION, THE REMAINING BALANCE IN THE ACCOUNT

1 DESCRIBED IN SUBDIVISION (A) SHALL BE RETURNED TO THAT ENROLLEE IN
2 THE FORM OF A VOUCHER FOR THE SOLE PURPOSE OF PURCHASING AND PAYING
3 FOR PRIVATE INSURANCE.

4 (F) BY JULY 1, 2014, DESIGN AND IMPLEMENT A CO-PAY STRUCTURE
5 THAT ENCOURAGES USE OF HIGH-VALUE SERVICES, WHILE DISCOURAGING LOW-
6 VALUE SERVICES SUCH AS NONURGENT EMERGENCY DEPARTMENT USE.

7 (G) DURING THE ENROLLMENT PROCESS, INFORM ENROLLEES DESCRIBED
8 IN SUBDIVISION (A) ABOUT ADVANCE DIRECTIVES AND REQUIRE THE
9 ENROLLEES TO COMPLETE A DEPARTMENT OF COMMUNITY HEALTH-APPROVED
10 ADVANCE DIRECTIVE ON A FORM THAT INCLUDES AN OPTION TO DECLINE. THE
11 ADVANCE DIRECTIVES RECEIVED FROM ENROLLEES AS PROVIDED IN THIS
12 SUBDIVISION SHALL BE TRANSMITTED TO THE PEACE OF MIND REGISTRY
13 ORGANIZATION TO BE PLACED ON THE PEACE OF MIND REGISTRY.

14 (H) BY APRIL 1, 2015, DEVELOP INCENTIVES FOR ENROLLEES AND
15 PROVIDERS WHO ASSIST THE DEPARTMENT OF COMMUNITY HEALTH IN
16 DETECTING FRAUD AND ABUSE IN THE MEDICAL ASSISTANCE PROGRAM. THE
17 DEPARTMENT OF COMMUNITY HEALTH SHALL PROVIDE AN ANNUAL REPORT THAT
18 INCLUDES THE TYPE OF FRAUD DETECTED, THE AMOUNT SAVED, AND THE
19 OUTCOME OF THE INVESTIGATION TO THE LEGISLATURE.

20 (I) ALLOW FOR SERVICES PROVIDED BY TELEMEDICINE FROM A
21 PRACTITIONER WHO IS LICENSED, REGISTERED, OR OTHERWISE AUTHORIZED
22 UNDER SECTION 16171 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL
23 333.16171, TO ENGAGE IN HIS OR HER HEALTH CARE PROFESSION IN THE
24 STATE WHERE THE PATIENT IS LOCATED.

25 (2) FOR SERVICES RENDERED TO AN UNINSURED INDIVIDUAL, A
26 HOSPITAL THAT PARTICIPATES IN THE MEDICAL ASSISTANCE PROGRAM UNDER
27 THIS ACT SHALL ACCEPT 115% OF MEDICARE RATES AS PAYMENTS IN FULL

1 FROM AN UNINSURED INDIVIDUAL WITH AN ANNUAL INCOME LEVEL UP TO **<<250%>>**
2 OF THE FEDERAL POVERTY GUIDELINES. THIS SUBSECTION APPLIES WHETHER
3 OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED UNDER THIS SECTION
4 ARE APPROVED, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IS
5 REPEALED, OR THE STATE TERMINATES OR OPTS OUT OF THE PROGRAM
6 ESTABLISHED UNDER THIS SECTION.
7 (3) NOT MORE THAN 7 CALENDAR DAYS AFTER RECEIVING EACH OF THE
8 OFFICIAL WAIVER-RELATED WRITTEN CORRESPONDENCE FROM THE UNITED
9 STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO IMPLEMENT THE
10 PROVISIONS OF THIS SECTION, THE DEPARTMENT OF COMMUNITY HEALTH
11 SHALL SUBMIT A WRITTEN COPY OF THE APPROVED WAIVER PROVISIONS TO
12 THE LEGISLATURE FOR REVIEW.
13 (4) BY SEPTEMBER 30, 2015, THE DEPARTMENT OF COMMUNITY HEALTH
14 SHALL DEVELOP AND IMPLEMENT A PLAN TO ENROLL ALL EXISTING FEE-FOR-
15 SERVICE ENROLLEES INTO CONTRACTED HEALTH PLANS IF ALLOWABLE BY LAW,
16 IF THE MEDICAL ASSISTANCE PROGRAM IS THE PRIMARY PAYER AND IF THAT
17 ENROLLMENT IS COST-EFFECTIVE. THIS INCLUDES ALL NEWLY ELIGIBLE
18 ENROLLEES AS DESCRIBED IN SUBSECTION (1)(A). THE DEPARTMENT OF
19 COMMUNITY HEALTH SHALL INCLUDE CONTRACTED HEALTH PLANS AS THE
20 MANDATORY DELIVERY SYSTEM IN ITS WAIVER REQUEST. THE DEPARTMENT OF
21 COMMUNITY HEALTH ALSO SHALL PURSUE ANY AND ALL NECESSARY WAIVERS TO
22 ENROLL PERSONS ELIGIBLE FOR BOTH MEDICAID AND MEDICARE INTO THE 4
23 INTEGRATED CARE DEMONSTRATION REGIONS BEGINNING JULY 1, 2014. BY
24 SEPTEMBER 30, 2015, THE DEPARTMENT OF COMMUNITY HEALTH SHALL
25 IDENTIFY ALL REMAINING POPULATIONS ELIGIBLE FOR MANAGED CARE,
26 DEVELOP PLANS FOR THEIR INTEGRATION INTO MANAGED CARE, AND PROVIDE
27 RECOMMENDATIONS FOR A PERFORMANCE BONUS INCENTIVE PLAN MECHANISM

1 FOR LONG-TERM CARE MANAGED CARE PROVIDERS THAT ARE CONSISTENT WITH
2 OTHER MANAGED CARE PERFORMANCE BONUS INCENTIVE PLANS. BY SEPTEMBER
3 30, 2015, THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE
4 RECOMMENDATIONS FOR A PERFORMANCE BONUS INCENTIVE PLAN FOR LONG-
5 TERM CARE MANAGED CARE PROVIDERS OF UP TO 3% OF THEIR MEDICAID
6 CAPITATION PAYMENTS, CONSISTENT WITH OTHER MANAGED CARE PERFORMANCE
7 BONUS INCENTIVE PLANS. THESE PAYMENTS SHALL COMPLY WITH FEDERAL
8 REQUIREMENTS AND SHALL BE BASED ON MEASURES THAT IDENTIFY THE
9 APPROPRIATE USE OF LONG-TERM CARE SERVICES AND THAT FOCUS ON
10 CONSUMER SATISFACTION, CONSUMER CHOICE, AND OTHER APPROPRIATE
11 QUALITY MEASURES APPLICABLE TO COMMUNITY-BASED AND NURSING HOME
12 SERVICES. WHERE APPROPRIATE, THESE QUALITY MEASURES SHALL BE
13 CONSISTENT WITH QUALITY MEASURES USED FOR SIMILAR SERVICES
14 IMPLEMENTED BY THE INTEGRATED CARE FOR DUALS DEMONSTRATION PROJECT.
15 THIS SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE
16 WAIVERS REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT
17 PROTECTION AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE
18 TERMINATES OR OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS
19 SECTION.
20 (5) BY SEPTEMBER 30, 2016, THE DEPARTMENT OF COMMUNITY HEALTH
21 SHALL IMPLEMENT A PHARMACEUTICAL BENEFIT THAT UTILIZES CO-PAYS AT
22 APPROPRIATE LEVELS ALLOWABLE BY THE CENTERS FOR MEDICARE AND
23 MEDICAID SERVICES TO ENCOURAGE THE USE OF HIGH-VALUE, LOW-COST
24 PRESCRIPTIONS, SUCH AS GENERIC PRESCRIPTIONS WHEN SUCH AN
25 ALTERNATIVE EXISTS FOR A BRANDED PRODUCT AND 90-DAY PRESCRIPTION
26 SUPPLIES, AS RECOMMENDED BY THE ENROLLEE'S PRESCRIBING PROVIDER AND
27 AS IS CONSISTENT WITH SECTION 109H AND SECTIONS 9701 TO 9709 OF THE

1 PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.9701 TO 333.9709. THIS
2 SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS
3 REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT PROTECTION
4 AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR
5 OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.
6 (6) THE DEPARTMENT OF COMMUNITY HEALTH SHALL WORK WITH
7 PROVIDERS, CONTRACTED HEALTH PLANS, AND OTHER DEPARTMENTS AS
8 NECESSARY TO CREATE PROCESSES THAT REDUCE THE AMOUNT OF UNCOLLECTED
9 COST-SHARING AND REDUCE THE ADMINISTRATIVE COST OF COLLECTING COST-
10 SHARING. TO THIS END, A MINIMUM 0.25% OF PAYMENTS TO CONTRACTED
11 HEALTH PLANS SHALL BE WITHHELD FOR THE PURPOSE OF ESTABLISHING A
12 COST-SHARING COMPLIANCE BONUS POOL BEGINNING OCTOBER 1, 2015. THE
13 DISTRIBUTION OF FUNDS FROM THE COST-SHARING COMPLIANCE POOL SHALL
14 BE BASED ON THE CONTRACTED HEALTH PLANS' SUCCESS IN COLLECTING
15 COST-SHARING PAYMENTS. THE DEPARTMENT OF COMMUNITY HEALTH SHALL
16 DEVELOP THE METHODOLOGY FOR DISTRIBUTION OF THESE FUNDS. THIS
17 SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS
18 REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT PROTECTION
19 AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR
20 OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.
21 (7) BY JUNE 1, 2014, THE DEPARTMENT OF COMMUNITY HEALTH SHALL
22 DEVELOP A METHODOLOGY THAT DECREASES THE AMOUNT AN ENROLLEE'S
23 REQUIRED CONTRIBUTION MAY BE REDUCED AS DESCRIBED IN SUBSECTION
24 (1)(E) BASED ON, BUT NOT LIMITED TO, FACTORS SUCH AS AN ENROLLEE'S
25 FAILURE TO PAY COST-SHARING REQUIREMENTS AND THE ENROLLEE'S
26 INAPPROPRIATE UTILIZATION OF EMERGENCY DEPARTMENTS.
27 (8) THE PROGRAM DESCRIBED IN THIS SECTION IS CREATED IN PART

1 TO EXTEND HEALTH COVERAGE TO THE STATE'S LOW-INCOME CITIZENS AND TO
2 PROVIDE HEALTH INSURANCE COST RELIEF TO INDIVIDUALS AND TO THE
3 BUSINESS COMMUNITY BY REDUCING THE COST SHIFT ATTENDANT TO
4 UNCOMPENSATED CARE. UNCOMPENSATED CARE DOES NOT INCLUDE COURTESY
5 ALLOWANCES OR DISCOUNTS GIVEN TO PATIENTS. THE MEDICAID HOSPITAL
6 COST REPORT SHALL BE PART OF THE UNCOMPENSATED CARE DEFINITION AND
7 CALCULATION. IN ADDITION TO THE MEDICAID HOSPITAL COST REPORT, THE
8 DEPARTMENT OF COMMUNITY HEALTH SHALL COLLECT AND EXAMINE OTHER
9 RELEVANT FINANCIAL DATA FOR ALL HOSPITALS AND EVALUATE THE IMPACT
10 THAT PROVIDING MEDICAL COVERAGE TO THE EXPANDED POPULATION OF
11 ENROLLEES DESCRIBED IN SUBSECTION (1)(A) HAS HAD ON THE ACTUAL COST
12 OF UNCOMPENSATED CARE. THIS SHALL BE REPORTED FOR ALL HOSPITALS IN
13 THE STATE. BY DECEMBER 31, 2014, THE DEPARTMENT OF COMMUNITY HEALTH
14 SHALL MAKE AN INITIAL BASELINE UNCOMPENSATED CARE REPORT CONTAINING
15 AT LEAST THE DATA DESCRIBED IN THIS SUBSECTION TO THE LEGISLATURE
16 AND EACH DECEMBER 31 AFTER THAT SHALL MAKE A REPORT REGARDING THE
17 PRECEDING FISCAL YEAR'S EVIDENCE OF THE REDUCTION IN THE AMOUNT OF
18 THE ACTUAL COST OF UNCOMPENSATED CARE COMPARED TO THE INITIAL
19 BASELINE REPORT. THE BASELINE REPORT SHALL USE FISCAL YEAR 2012-
20 2013 DATA. BASED ON THE EVIDENCE OF THE REDUCTION IN THE AMOUNT OF
21 THE ACTUAL COST OF UNCOMPENSATED CARE BORNE BY THE HOSPITALS IN
22 THIS STATE, BEGINNING APRIL 1, 2015, THE DEPARTMENT OF COMMUNITY
23 HEALTH SHALL PROPORTIONALLY REDUCE THE DISPROPORTIONATE SHARE
24 PAYMENTS TO ALL HOSPITALS AND HOSPITAL SYSTEMS FOR THE PURPOSE OF
25 PRODUCING GENERAL FUND SAVINGS. THE DEPARTMENT OF COMMUNITY HEALTH
26 SHALL RECOGNIZE ANY SAVINGS FROM THIS REDUCTION BY SEPTEMBER 30,
27 2016. ALL THE REPORTS REQUIRED UNDER THIS SUBSECTION SHALL BE MADE

1 AVAILABLE TO THE LEGISLATURE AND SHALL BE EASILY ACCESSIBLE ON THE
2 DEPARTMENT OF COMMUNITY HEALTH'S WEBSITE.
3 (9) THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES SHALL
4 EXAMINE THE FINANCIAL REPORTS OF HEALTH INSURERS AND EVALUATE THE
5 IMPACT THAT PROVIDING MEDICAL COVERAGE TO THE EXPANDED POPULATION
6 OF ENROLLEES DESCRIBED IN SUBSECTION (1)(A) HAS HAD ON THE COST OF
7 UNCOMPENSATED CARE AS IT RELATES TO INSURANCE RATES AND INSURANCE
8 RATE CHANGE FILINGS, AS WELL AS ITS RESULTING NET EFFECT ON RATES
9 OVERALL. THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES SHALL
10 CONSIDER THE EVALUATION DESCRIBED IN THIS SUBSECTION IN THE ANNUAL
11 APPROVAL OF RATES. BY DECEMBER 31, 2014, THE DEPARTMENT OF
12 INSURANCE AND FINANCIAL SERVICES SHALL MAKE AN INITIAL BASELINE
13 REPORT TO THE LEGISLATURE REGARDING RATES AND EACH DECEMBER 31
14 AFTER THAT SHALL MAKE A REPORT REGARDING THE EVIDENCE OF THE CHANGE
15 IN RATES COMPARED TO THE INITIAL BASELINE REPORT. ALL THE REPORTS
16 REQUIRED UNDER THIS SUBSECTION SHALL BE MADE AVAILABLE TO THE
17 LEGISLATURE AND SHALL BE MADE AVAILABLE AND EASILY ACCESSIBLE ON
18 THE DEPARTMENT OF COMMUNITY HEALTH'S WEBSITE.
19 (10) THE DEPARTMENT OF COMMUNITY HEALTH SHALL EXPLORE AND
20 DEVELOP A RANGE OF INNOVATIONS AND INITIATIVES TO IMPROVE THE
21 EFFECTIVENESS AND PERFORMANCE OF THE MEDICAL ASSISTANCE PROGRAM AND
22 TO LOWER OVERALL HEALTH CARE COSTS IN THIS STATE. THE DEPARTMENT OF
23 COMMUNITY HEALTH SHALL REPORT THE RESULTS OF THE EFFORTS DESCRIBED
24 IN THIS SUBSECTION TO THE LEGISLATURE AND TO THE HOUSE AND SENATE
25 FISCAL AGENCIES BY SEPTEMBER 30, 2015. THE REPORT REQUIRED UNDER
26 THIS SUBSECTION SHALL ALSO BE MADE AVAILABLE AND EASILY ACCESSIBLE
27 ON THE DEPARTMENT OF COMMUNITY HEALTH'S WEBSITE. THE DEPARTMENT OF

1 COMMUNITY HEALTH SHALL PURSUE A BROAD RANGE OF INNOVATIONS AND
2 INITIATIVES AS TIME AND RESOURCES ALLOW THAT SHALL INCLUDE, AT A
3 MINIMUM, ALL OF THE FOLLOWING:
4 (A) THE VALUE AND COST-EFFECTIVENESS OF OPTIONAL MEDICAID
5 BENEFITS AS DESCRIBED IN FEDERAL STATUTE.
6 (B) THE IDENTIFICATION OF PRIVATE SECTOR, PRIMARILY SMALL
7 BUSINESS, HEALTH COVERAGE BENEFIT DIFFERENCES COMPARED TO THE
8 MEDICAL ASSISTANCE PROGRAM SERVICES AND JUSTIFICATION FOR THE
9 DIFFERENCES.
10 (C) THE MINIMUM MEASURES AND DATA SETS REQUIRED TO EFFECTIVELY
11 MEASURE THE MEDICAL ASSISTANCE PROGRAM'S RETURN ON INVESTMENT FOR
12 TAXPAYERS.
13 (D) REVIEW AND EVALUATION OF THE EFFECTIVENESS OF CURRENT
14 INCENTIVES FOR CONTRACTED HEALTH PLANS, PROVIDERS, AND
15 BENEFICIARIES WITH RECOMMENDATIONS FOR EXPANDING AND REFINING
16 INCENTIVES TO ACCELERATE IMPROVEMENT IN HEALTH OUTCOMES, HEALTHY
17 BEHAVIORS, AND COST-EFFECTIVENESS AND REVIEW OF THE COMPLIANCE OF
18 REQUIRED CONTRIBUTIONS AND CO-PAYS.
19 (E) REVIEW AND EVALUATION OF THE CURRENT DESIGN PRINCIPLES
20 THAT SERVE AS THE FOUNDATION FOR THE STATE'S MEDICAL ASSISTANCE
21 PROGRAM TO ENSURE THE PROGRAM IS COST-EFFECTIVE AND THAT
22 APPROPRIATE INCENTIVE MEASURES ARE UTILIZED. THE REVIEW SHALL
23 INCLUDE, AT A MINIMUM, THE AUTO-ASSIGNMENT ALGORITHM AND
24 PERFORMANCE BONUS INCENTIVE POOL. THIS SUBSECTION APPLIES WHETHER
25 OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED UNDER THIS SECTION
26 ARE APPROVED, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IS
27 REPEALED, OR THE STATE TERMINATES OR OPTS OUT OF THE PROGRAM

1 ESTABLISHED UNDER THIS SECTION.
2 (F) THE IDENTIFICATION OF PRIVATE SECTOR INITIATIVES USED TO
3 INCENT INDIVIDUALS TO COMPLY WITH MEDICAL ADVICE.
4 (11) BY DECEMBER 31, 2015, THE DEPARTMENT OF COMMUNITY HEALTH
5 SHALL REVIEW AND REPORT TO THE LEGISLATURE THE FEASIBILITY OF
6 PROGRAMS RECOMMENDED BY MULTIPLE NATIONAL ORGANIZATIONS THAT
7 INCLUDE, BUT ARE NOT LIMITED TO, THE COUNCIL OF STATE GOVERNMENTS,
8 THE NATIONAL CONFERENCE OF STATE LEGISLATURES, AND THE AMERICAN
9 LEGISLATIVE EXCHANGE COUNCIL, ON IMPROVING THE COST-EFFECTIVENESS
10 OF THE MEDICAL ASSISTANCE PROGRAM.
11 (12) BY JANUARY 1, 2014, THE DEPARTMENT OF COMMUNITY HEALTH IN
12 COLLABORATION WITH THE CONTRACTED HEALTH PLANS AND PROVIDERS SHALL
13 CREATE FINANCIAL INCENTIVES FOR ALL OF THE FOLLOWING:
14 (A) CONTRACTED HEALTH PLANS THAT MEET SPECIFIED POPULATION
15 IMPROVEMENT GOALS.
16 (B) PROVIDERS WHO MEET SPECIFIED QUALITY, COST, AND
17 UTILIZATION TARGETS.
18 (C) ENROLLEES WHO DEMONSTRATE IMPROVED HEALTH OUTCOMES OR
19 MAINTAIN HEALTHY BEHAVIORS AS IDENTIFIED IN A HEALTH RISK
20 ASSESSMENT AS IDENTIFIED BY THEIR PRIMARY CARE PRACTITIONER WHO IS
21 LICENSED, REGISTERED, OR OTHERWISE AUTHORIZED TO ENGAGE IN HIS OR
22 HER HEALTH CARE PROFESSION IN THIS STATE. THIS SUBSECTION APPLIES
23 WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED UNDER THIS
24 SECTION ARE APPROVED, THE PATIENT PROTECTION AND AFFORDABLE CARE
25 ACT IS REPEALED, OR THE STATE TERMINATES OR OPTS OUT OF THE PROGRAM
26 ESTABLISHED UNDER THIS SECTION.
27 (13) BY OCTOBER 1, 2015, THE PERFORMANCE BONUS INCENTIVE POOL

1 FOR CONTRACTED HEALTH PLANS THAT ARE NOT SPECIALTY PREPAID HEALTH
2 PLANS SHALL INCLUDE INAPPROPRIATE UTILIZATION OF EMERGENCY
3 DEPARTMENTS, AMBULATORY CARE, CONTRACTED HEALTH PLAN ALL-CAUSE
4 ACUTE 30-DAY READMISSION RATES, AND GENERIC DRUG UTILIZATION WHEN
5 SUCH AN ALTERNATIVE EXISTS FOR A BRANDED PRODUCT AND CONSISTENT
6 WITH SECTION 109H AND SECTIONS 9701 TO 9709 OF THE PUBLIC HEALTH
7 CODE, 1978 PA 368, MCL 333.9701 TO 333.9709, AS A PERCENTAGE OF
8 TOTAL. THESE MEASUREMENT TOOLS SHALL BE CONSIDERED AND WEIGHED
9 WITHIN THE 6 HIGHEST FACTORS USED IN THE FORMULA. THIS SUBSECTION
10 APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED
11 UNDER THIS SECTION ARE APPROVED, THE PATIENT PROTECTION AND
12 AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR OPTS
13 OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.
14 (14) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ENSURE THAT ALL
15 CAPITATED PAYMENTS MADE TO CONTRACTED HEALTH PLANS ARE ACTUARIALLY
16 SOUND. THIS SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE
17 WAIVERS REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT
18 PROTECTION AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE
19 TERMINATES OR OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS
20 SECTION.
21 (15) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAINTAIN
22 ADMINISTRATIVE COSTS AT A LEVEL OF NOT MORE THAN 1% OF THE
23 DEPARTMENT OF COMMUNITY HEALTH'S APPROPRIATION OF THE STATE MEDICAL
24 ASSISTANCE PROGRAM. THESE ADMINISTRATIVE COSTS SHALL BE CAPPED AT
25 THE TOTAL ADMINISTRATIVE COSTS FOR THE FISCAL YEAR ENDING SEPTEMBER
26 30, 2016, EXCEPT FOR INFLATION AND PROJECT-RELATED COSTS REQUIRED
27 TO ACHIEVE MEDICAL ASSISTANCE NET GENERAL FUND SAVINGS. THIS

1 **SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS**
2 **REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT PROTECTION**
3 **AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR**
4 **OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.**
5 **(16) BY OCTOBER 1, 2015, THE DEPARTMENT OF COMMUNITY HEALTH**
6 **SHALL ESTABLISH UNIFORM PROCEDURES AND COMPLIANCE METRICS FOR**
7 **UTILIZATION BY THE CONTRACTED HEALTH PLANS TO ENSURE THAT COST-**
8 **SHARING REQUIREMENTS ARE BEING MET. THIS SHALL INCLUDE**
9 **RAMIFICATIONS FOR THE CONTRACTED HEALTH PLANS' FAILURE TO COMPLY**
10 **WITH PERFORMANCE OR COMPLIANCE METRICS. THIS SUBSECTION APPLIES**
11 **WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED UNDER THIS**
12 **SECTION ARE APPROVED, THE PATIENT PROTECTION AND AFFORDABLE CARE**
13 **ACT IS REPEALED, OR THE STATE TERMINATES OR OPTS OUT OF THE PROGRAM**
14 **ESTABLISHED UNDER THIS SECTION.**
15 **(17) BEGINNING OCTOBER 1, 2015, THE DEPARTMENT OF COMMUNITY**
16 **HEALTH SHALL WITHHOLD, AT A MINIMUM, 0.75% OF PAYMENTS TO**
17 **CONTRACTED HEALTH PLANS, EXCEPT FOR SPECIALTY PREPAID HEALTH PLANS,**
18 **FOR THE PURPOSE OF EXPANDING THE EXISTING PERFORMANCE BONUS**
19 **INCENTIVE POOL. DISTRIBUTION OF FUNDS FROM THE PERFORMANCE BONUS**
20 **INCENTIVE POOL IS CONTINGENT ON THE CONTRACTED HEALTH PLAN'S**
21 **COMPLETION OF THE REQUIRED PERFORMANCE OR COMPLIANCE METRICS. THIS**
22 **SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS**
23 **REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT PROTECTION**
24 **AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR**
25 **OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.**
26 **(18) BY OCTOBER 1, 2015, THE DEPARTMENT OF COMMUNITY HEALTH**
27 **SHALL WITHHOLD, AT A MINIMUM, 0.75% OF PAYMENTS TO SPECIALTY**

1 **PREPAID HEALTH PLANS FOR THE PURPOSE OF ESTABLISHING A PERFORMANCE**
2 **BONUS INCENTIVE POOL. DISTRIBUTION OF FUNDS FROM THE PERFORMANCE**
3 **BONUS INCENTIVE POOL IS CONTINGENT ON THE SPECIALTY PREPAID HEALTH**
4 **PLAN'S COMPLETION OF THE REQUIRED PERFORMANCE OF COMPLIANCE**
5 **METRICS, WHICH SHALL INCLUDE, AT A MINIMUM, PARTNERING WITH OTHER**
6 **CONTRACTED HEALTH PLANS TO REDUCE NONEMERGENT EMERGENCY DEPARTMENT**
7 **UTILIZATION, INCREASED PARTICIPATION IN PATIENT-CENTERED MEDICAL**
8 **HOMES, INCREASED USE OF ELECTRONIC HEALTH RECORDS AND DATA SHARING**
9 **WITH OTHER PROVIDERS, AND IDENTIFICATION OF ENROLLEES WHO MAY BE**
10 **ELIGIBLE FOR SERVICES THROUGH THE VETERANS ADMINISTRATION. THIS**
11 **SUBSECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS**
12 **REQUESTED UNDER THIS SECTION ARE APPROVED, THE PATIENT PROTECTION**
13 **AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR**
14 **OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.**
15 **(19) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MEASURE**
16 **CONTRACTED HEALTH PLAN OR SPECIALTY PREPAID HEALTH PLAN PERFORMANCE**
17 **METRICS, AS APPLICABLE, ON APPLICATION OF STANDARDS OF CARE AS THAT**
18 **RELATES TO APPROPRIATE TREATMENT OF SUBSTANCE USE DISORDERS AND**
19 **EFFORTS TO REDUCE SUBSTANCE USE DISORDERS. THIS SUBSECTION APPLIES**
20 **WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED UNDER THIS**
21 **SECTION ARE APPROVED, THE PATIENT PROTECTION AND AFFORDABLE CARE**
22 **ACT IS REPEALED, OR THE STATE TERMINATES OR OPTS OUT OF THE PROGRAM**
23 **ESTABLISHED UNDER THIS SECTION.**
24 **(20) BY SEPTEMBER 1, 2015, IN ADDITION TO THE WAIVER REQUESTED**
25 **IN SUBSECTION (1), THE DEPARTMENT OF COMMUNITY HEALTH SHALL SEEK AN**
26 **ADDITIONAL WAIVER FROM THE UNITED STATES DEPARTMENT OF HEALTH AND**
27 **HUMAN SERVICES THAT REQUIRES INDIVIDUALS WHO ARE BETWEEN 100% AND**

1 133% OF THE FEDERAL POVERTY GUIDELINES AND WHO HAVE HAD MEDICAL
2 ASSISTANCE COVERAGE FOR 48 CUMULATIVE MONTHS BEGINNING ON THE DATE
3 OF THEIR ENROLLMENT INTO THE PROGRAM DESCRIBED IN SUBSECTION (1) TO
4 CHOOSE 1 OF THE FOLLOWING OPTIONS:
5 (A) CHANGE THEIR MEDICAL ASSISTANCE PROGRAM ELIGIBILITY
6 STATUS, IN ACCORDANCE WITH FEDERAL LAW, TO BE CONSIDERED ELIGIBLE
7 FOR FEDERAL ADVANCE PREMIUM TAX CREDIT AND COST-SHARING SUBSIDIES
8 FROM THE FEDERAL GOVERNMENT TO PURCHASE PRIVATE INSURANCE COVERAGE
9 THROUGH AN AMERICAN HEALTH BENEFIT EXCHANGE WITHOUT FINANCIAL
10 PENALTY TO THE STATE.
11 (B) REMAIN IN THE MEDICAL ASSISTANCE PROGRAM BUT INCREASE
12 COST-SHARING REQUIREMENTS UP TO 7% OF INCOME. REQUIRED
13 CONTRIBUTIONS SHALL BE DEPOSITED INTO AN ACCOUNT USED TO PAY FOR
14 INCURRED HEALTH EXPENSES FOR COVERED BENEFITS AND SHALL BE 3.5% OF
15 INCOME BUT MAY BE REDUCED AS PROVIDED IN SUBSECTION (1)(E). THE
16 DEPARTMENT OF COMMUNITY HEALTH MAY REDUCE CO-PAYS AS PROVIDED IN
17 SUBSECTION (1)(E), BUT NOT UNTIL ANNUAL ACCUMULATED CO-PAYS REACH
18 3% OF INCOME.
19 (21) THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOTIFY ENROLLEES
20 60 DAYS BEFORE THE END OF THE ENROLLEE'S FORTY-EIGHTH MONTH THAT
21 COVERAGE UNDER THE CURRENT PROGRAM IS NO LONGER AVAILABLE TO THEM
22 AND THAT, IN ORDER TO CONTINUE COVERAGE, THE ENROLLEE MUST CHOOSE
23 BETWEEN THE OPTIONS DESCRIBED IN SUBSECTION (20)(A) OR (B).
24 (22) THE DEPARTMENT OF COMMUNITY HEALTH SHALL IMPLEMENT A
25 SYSTEM FOR INDIVIDUALS WHO FAIL TO CHOOSE AN OPTION DESCRIBED UNDER
26 SUBSECTION (20)(A) OR (B) WITHIN A SPECIFIED TIME DETERMINED BY THE
27 DEPARTMENT OF COMMUNITY HEALTH THAT ENROLLS THOSE INDIVIDUALS INTO

1 THE OPTION DESCRIBED IN SUBSECTION (20)(B).
2 (23) IF THE WAIVER REQUESTED UNDER SUBSECTION (20) IS NOT
3 APPROVED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
4 SERVICES BY DECEMBER 31, 2015, MEDICAL COVERAGE FOR INDIVIDUALS
5 DESCRIBED IN SUBSECTION (1)(A) SHALL NO LONGER BE PROVIDED. IF THE
6 WAIVER IS NOT APPROVED BY DECEMBER 31, 2015, THEN BY JANUARY 31,
7 2016, THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOTIFY ENROLLEES
8 THAT THE PROGRAM DESCRIBED IN SUBSECTION (1) SHALL BE TERMINATED ON
9 APRIL 30, 2016. IF A WAIVER REQUESTED UNDER SUBSECTION (1) OR (20)
10 IS APPROVED AND IS REQUIRED TO BE RENEWED AT ANY TIME AFTER
11 APPROVAL, MEDICAL COVERAGE FOR INDIVIDUALS DESCRIBED IN SUBSECTION
12 (1)(A) SHALL NO LONGER BE PROVIDED IF EITHER RENEWAL REQUEST IS NOT
13 APPROVED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
14 SERVICES OR IF A WAIVER IS CANCELED AFTER APPROVAL. THE DEPARTMENT
15 OF COMMUNITY HEALTH SHALL GIVE ENROLLEES 4 MONTHS' ADVANCE NOTICE
16 BEFORE TERMINATION OF COVERAGE BASED ON A RENEWAL REQUEST NOT BEING
17 APPROVED AS DESCRIBED IN THIS SUBSECTION. A NOTIFICATION DESCRIBED
18 IN THIS SUBSECTION SHALL STATE THAT THE ENROLLMENT WAS TERMINATED
19 DUE TO THE FAILURE OF THE UNITED STATES DEPARTMENT OF HEALTH AND
20 HUMAN SERVICES TO APPROVE THE WAIVER REQUESTED UNDER SUBSECTION
21 (20) OR RENEWAL OF A WAIVER DESCRIBED IN THIS SUBSECTION.
22 (24) INDIVIDUALS DESCRIBED IN 42 CFR 440.315 ARE NOT SUBJECT
23 TO THE PROVISIONS OF THE WAIVER DESCRIBED IN SUBSECTION (20).
24 (25) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE AVAILABLE
25 AT LEAST 3 YEARS OF STATE MEDICAL ASSISTANCE PROGRAM DATA, WITHOUT
26 CHARGE, TO ANY VENDOR CONSIDERED QUALIFIED BY THE DEPARTMENT OF
27 COMMUNITY HEALTH WHO INDICATES INTEREST IN SUBMITTING PROPOSALS TO

1 **CONTRACTED HEALTH PLANS IN ORDER TO IMPLEMENT COST SAVINGS AND**
2 **POPULATION HEALTH IMPROVEMENT OPPORTUNITIES THROUGH THE USE OF**
3 **INNOVATIVE INFORMATION AND DATA MANAGEMENT TECHNOLOGIES. ANY**
4 **PROGRAM OR PROPOSAL TO THE CONTRACTED HEALTH PLANS MUST BE**
5 **CONSISTENT WITH THE STATE'S GOALS OF IMPROVING HEALTH, INCREASING**
6 **THE QUALITY, RELIABILITY, AVAILABILITY, AND CONTINUITY OF CARE, AND**
7 **REDUCING THE COST OF CARE OF THE ELIGIBLE POPULATION OF ENROLLEES**
8 **DESCRIBED IN SUBSECTION (1)(A). THE USE OF THE DATA DESCRIBED IN**
9 **THIS SUBSECTION FOR THE PURPOSE OF ASSESSING THE POTENTIAL**
10 **OPPORTUNITY AND SUBSEQUENT DEVELOPMENT AND SUBMISSION OF FORMAL**
11 **PROPOSALS TO CONTRACTED HEALTH PLANS IS NOT A COST OR CONTRACTUAL**
12 **OBLIGATION TO THE DEPARTMENT OF COMMUNITY HEALTH OR THE STATE.**
13 **(26) IF THE DEPARTMENT OF COMMUNITY HEALTH DOES NOT RECEIVE**
14 **APPROVAL FOR BOTH OF THE WAIVERS REQUIRED UNDER THIS SECTION BEFORE**
15 **DECEMBER 31, 2015, THE PROGRAM DESCRIBED IN THIS SECTION IS**
16 **TERMINATED. THE DEPARTMENT OF COMMUNITY HEALTH SHALL REQUEST**
17 **WRITTEN DOCUMENTATION FROM THE UNITED STATES DEPARTMENT OF HEALTH**
18 **AND HUMAN SERVICES THAT IF THE WAIVERS DESCRIBED IN THIS SECTION**
19 **ARE REJECTED CAUSING THE MEDICAL ASSISTANCE PROGRAM TO REVERT BACK**
20 **TO THE ELIGIBILITY REQUIREMENTS IN EFFECT ON THE EFFECTIVE DATE OF**
21 **THE AMENDATORY ACT THAT ADDED THIS SECTION, EXCLUDING ANY WAIVERS**
22 **THAT HAVE NOT BEEN RENEWED, THERE SHALL BE NO FINANCIAL FEDERAL**
23 **FUNDING PENALTY TO THE STATE ASSOCIATED WITH THE IMPLEMENTATION AND**
24 **SUBSEQUENT CANCELLATION OF THE PROGRAM CREATED IN THIS SECTION. IF**
25 **THE DEPARTMENT OF COMMUNITY HEALTH DOES NOT RECEIVE THIS**
26 **DOCUMENTATION BY DECEMBER 31, 2013, THE DEPARTMENT OF COMMUNITY**
27 **HEALTH SHALL NOT IMPLEMENT THE PROGRAM DESCRIBED IN THIS SECTION.**

1 **(27) THIS SECTION DOES NOT APPLY IF EITHER OF THE FOLLOWING**
2 **OCCURS:**
3 **(A) IF THE DEPARTMENT OF COMMUNITY HEALTH IS UNABLE TO OBTAIN**
4 **EITHER OF THE FEDERAL WAIVERS REQUESTED IN SUBSECTION (1) OR (20).**
5 **(B) IF FEDERAL GOVERNMENT MATCHING FUNDS FOR THE PROGRAM**
6 **DESCRIBED IN THIS SECTION ARE REDUCED BELOW 100% AND ANNUAL STATE**
7 **SAVINGS AND OTHER NONFEDERAL NET SAVINGS ASSOCIATED WITH THE**
8 **IMPLEMENTATION OF THAT PROGRAM ARE NOT SUFFICIENT TO COVER THE**
9 **REDUCED FEDERAL MATCH. THE DEPARTMENT OF COMMUNITY HEALTH SHALL**
10 **DETERMINE AND THE STATE BUDGET OFFICE SHALL APPROVE HOW ANNUAL**
11 **STATE SAVINGS AND OTHER NONFEDERAL NET SAVINGS SHALL BE CALCULATED**
12 **BY JUNE 1, 2014. BY SEPTEMBER 1, 2014, THE CALCULATIONS AND**
13 **METHODOLOGY USED TO DETERMINE THE STATE AND OTHER NONFEDERAL NET**
14 **SAVINGS SHALL BE SUBMITTED TO THE LEGISLATURE.**
15 **(28) THE DEPARTMENT OF COMMUNITY HEALTH SHALL DEVELOP,**
16 **ADMINISTER, AND COORDINATE WITH THE DEPARTMENT OF TREASURY A**
17 **PROCEDURE FOR OFFSETTING THE STATE TAX REFUNDS OF AN ENROLLEE WHO**
18 **OWES A LIABILITY TO THE STATE OF PAST DUE UNCOLLECTED COST-SHARING,**
19 **AS ALLOWABLE BY THE FEDERAL GOVERNMENT. THE PROCEDURE SHALL INCLUDE**
20 **A GUIDELINE THAT THE DEPARTMENT OF COMMUNITY HEALTH SUBMIT TO THE**
21 **DEPARTMENT OF TREASURY, NOT LATER THAN NOVEMBER 1 OF EACH YEAR, ALL**
22 **REQUESTS FOR THE OFFSET OF STATE TAX REFUNDS CLAIMED ON RETURNS**
23 **FILED OR TO BE FILED FOR THAT TAX YEAR. FOR THE PURPOSE OF THIS**
24 **SUBSECTION, ANY NONPAYMENT OF THE COST-SHARING REQUIRED UNDER THIS**
25 **SECTION OWED BY THE ENROLLEE IS CONSIDERED A LIABILITY TO THE STATE**
26 **UNDER SECTION 30A(2)(B) OF 1941 PA 122, MCL 205.30A.**
27 **(29) FOR THE PURPOSE OF THIS SUBSECTION, ANY NONPAYMENT OF THE**

1 COST-SHARING REQUIRED UNDER THIS SECTION OWED BY THE ENROLLEE IS
2 CONSIDERED A CURRENT LIABILITY TO THE STATE UNDER SECTION 32 OF THE
3 MCCAULEY-TRAXLER-LAW-BOWMAN-MCNEELY LOTTERY ACT, 1972 PA 239, MCL
4 432.32, AND SHALL BE HANDLED IN ACCORDANCE WITH THE PROCEDURES FOR
5 HANDLING A LIABILITY TO THE STATE UNDER THAT SECTION, AS ALLOWED BY
6 THE FEDERAL GOVERNMENT.
7 (30) BY NOVEMBER 30, 2013, THE DEPARTMENT OF COMMUNITY HEALTH
8 SHALL CONVENE A SYMPOSIUM TO EXAMINE THE ISSUES OF EMERGENCY
9 DEPARTMENT OVERUTILIZATION AND IMPROPER USAGE. BY DECEMBER 31,
10 2014, THE DEPARTMENT OF COMMUNITY HEALTH SHALL SUBMIT A REPORT TO
11 THE LEGISLATURE THAT IDENTIFIES THE CAUSES OF OVERUTILIZATION AND
12 IMPROPER EMERGENCY SERVICE USAGE THAT INCLUDES SPECIFIC BEST
13 PRACTICE RECOMMENDATIONS FOR DECREASING OVERUTILIZATION OF
14 EMERGENCY DEPARTMENTS AND IMPROPER EMERGENCY SERVICE USAGE, AS WELL
15 AS HOW THOSE BEST PRACTICES ARE BEING IMPLEMENTED. BOTH BROAD
16 RECOMMENDATIONS AND SPECIFIC RECOMMENDATIONS RELATED TO THE
17 MEDICAID PROGRAM, ENROLLEE BEHAVIOR, AND HEALTH PLAN ACCESS ISSUES
18 SHALL BE INCLUDED.
19 (31) THE DEPARTMENT OF COMMUNITY HEALTH SHALL CONTRACT WITH AN
20 INDEPENDENT THIRD PARTY VENDOR TO REVIEW THE REPORTS REQUIRED IN
21 SUBSECTIONS (8) AND (9) AND OTHER DATA AS NECESSARY, IN ORDER TO
22 DEVELOP A METHODOLOGY FOR MEASURING, TRACKING, AND REPORTING
23 MEDICAL COST AND UNCOMPENSATED CARE COST REDUCTION OR RATE OF
24 INCREASE REDUCTION AND THEIR EFFECT ON HEALTH INSURANCE RATES ALONG
25 WITH RECOMMENDATIONS FOR ONGOING ANNUAL REVIEW. THE FINAL REPORT
26 AND RECOMMENDATIONS SHALL BE SUBMITTED TO THE LEGISLATURE BY
27 SEPTEMBER 30, 2015.

1 **(32) FOR THE PURPOSES OF SUBMITTING REPORTS AND OTHER**
2 **INFORMATION OR DATA REQUIRED UNDER THIS SECTION ONLY, "LEGISLATURE"**
3 **MEANS THE SENATE MAJORITY LEADER, THE SPEAKER OF THE HOUSE OF**
4 **REPRESENTATIVES, THE CHAIRS OF THE SENATE AND HOUSE OF**
5 **REPRESENTATIVES APPROPRIATIONS COMMITTEES, THE CHAIRS OF THE SENATE**
6 **AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON THE**
7 **DEPARTMENT OF COMMUNITY HEALTH BUDGET, AND THE CHAIRS OF THE SENATE**
8 **AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH POLICY.**
9 **(33) AS USED IN THIS SECTION:**
10 **(A) "PATIENT PROTECTION AND AFFORDABLE CARE ACT" MEANS THE**
11 **PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148, AS**
12 **AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT**
13 **OF 2010, PUBLIC LAW 111-152.**
14 **(B) "PEACE OF MIND REGISTRY" AND "PEACE OF MIND REGISTRY**
15 **ORGANIZATION" MEAN THOSE TERMS AS DEFINED IN SECTION 10301 OF THE**
16 **PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.10301.**
17 **(C) "STATE SAVINGS" MEANS ANY STATE FUND NET SAVINGS,**
18 **CALCULATED AS OF THE CLOSING OF THE FINANCIAL BOOKS FOR THE**
19 **DEPARTMENT OF COMMUNITY HEALTH AT THE END OF EACH FISCAL YEAR, THAT**
20 **RESULT FROM THE PROGRAM DESCRIBED IN THIS SECTION. THE SAVINGS**
21 **SHALL RESULT IN A REDUCTION IN SPENDING FROM THE FOLLOWING STATE**
22 **FUND ACCOUNTS: ADULT BENEFIT WAIVER, NON-MEDICAID COMMUNITY MENTAL**
23 **HEALTH, AND PRISONER HEALTH CARE. ANY IDENTIFIED SAVINGS FROM OTHER**
24 **STATE FUND ACCOUNTS SHALL BE PROPOSED TO THE HOUSE OF**
25 **REPRESENTATIVES AND SENATE APPROPRIATIONS COMMITTEES FOR APPROVAL**
26 **TO INCLUDE IN THAT YEAR'S STATE SAVINGS CALCULATION. IT IS THE**
27 **INTENT OF THE LEGISLATURE THAT FOR FISCAL YEAR ENDING SEPTEMBER 30,**

1 2014 ONLY, $193,000,000.00 OF THE STATE SAVINGS SHALL BE DEPOSITED
2 IN THE ROADS AND RISKS RESERVE FUND CREATED IN SECTION 211B OF
3 ARTICLE VIII OF 2013 PA 59.
4 (D) "TELEMEDICINE" MEANS THAT TERM AS DEFINED IN SECTION 3476
5 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3476.
6 SEC. 105E. (1) THERE IS APPROPRIATED FOR THE DEPARTMENT OF
7 COMMUNITY HEALTH AND THE DEPARTMENT OF CORRECTIONS TO SUPPLEMENT
8 APPROPRIATIONS FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2014 AN
9 ADJUSTED GROSS APPROPRIATION OF $1,524,903,500.00 APPROPRIATED FROM
10 $1,704,523,500.00 IN FEDERAL REVENUES, $13,145,000.00 IN OTHER
11 STATE RESTRICTED REVENUES AND A NEGATIVE APPROPRIATION OF
12 $192,765,000.00 IN STATE GENERAL FUND/GENERAL PURPOSE REVENUE.
13 (2) THERE IS APPROPRIATED FOR THE DEPARTMENT OF COMMUNITY
14 HEALTH FOR MEDICAID REFORM A GROSS APPROPRIATION OF
15 $1,549,115,700.00 APPROPRIATED FROM $1,704,523,500.00 IN FEDERAL
16 REVENUES, $13,145,000.00 IN OTHER STATE RESTRICTED REVENUES, AND A
17 NEGATIVE APPROPRIATION OF $168,552,800.00 IN STATE GENERAL
18 FUND/GENERAL PURPOSE REVENUE WITH $1,395,876,600.00 FOR MEDICAL
19 SERVICES REFORM, $288,646,900.00 FOR MENTAL HEALTH REFORM, AND
20 $40,000,000.00 FOR ADMINISTRATION, AND NEGATIVE APPROPRIATIONS TO
21 REFLECT SAVINGS WITH $1,072,200.00 FOR PLAN FIRST FAMILY PLANNING
22 WAIVER, $14,723,900.00 FOR MEDICAID ADULT BENEFITS WAIVER,
23 $6,680,600.00 FOR MEDICAID ADULT BENEFITS WAIVER (MENTAL HEALTH),
24 AND $152,931,100.00 FOR COMMUNITY MENTAL HEALTH NON-MEDICAID
25 SERVICES.
26 (3) THERE IS APPROPRIATED FOR THE DEPARTMENT OF CORRECTIONS A
27 NEGATIVE ADJUSTED GROSS APPROPRIATION OF $24,212,200.00 IN STATE

1 GENERAL FUND/GENERAL PURPOSE REVENUE WITH A NEGATIVE APPROPRIATION
2 OF $3,566,600.00 FOR PRISON RE-ENTRY AND COMMUNITY SUPPORT,
3 INCLUDING A NEGATIVE $377,200.00 FOR PRISONER RE-ENTRY LOCAL
4 SERVICE PROVIDERS AND A NEGATIVE $3,189,400.00 FOR PRISONER RE-
5 ENTRY DEPARTMENT OF CORRECTIONS PROGRAMS; A NEGATIVE APPROPRIATION
6 OF $8,066,100.00 FOR SUBSTANCE ABUSE TESTING AND TREATMENT SERVICES
7 IN FIELD OPERATIONS ADMINISTRATION; AND A NEGATIVE APPROPRIATION OF
8 $12,579,500.00 FOR PRISONER HEALTH CARE SERVICES IN HEALTH CARE.
9 (4) THE APPROPRIATIONS IN SUBSECTIONS (1), (2), AND (3) FOR
10 THE DEPARTMENT OF COMMUNITY HEALTH FOR MEDICAID REFORM ARE NOT
11 AVAILABLE FOR EXPENDITURE UNTIL APPROVAL OF THE FEDERAL WAIVER IN
12 SECTION 105D(1), EXCEPT THAT THE FUNDS ASSOCIATED WITH
13 ADMINISTRATIVE EXPENSES ARE AVAILABLE FOR IMMEDIATE EXPENDITURE.
14 THE ADMINISTRATIVE EXPENDITURES SHALL NOT EXCEED $20,000,000.00 IN
15 GENERAL FUND. THE DEPARTMENT OF COMMUNITY HEALTH SHALL ENTER INTO
16 MEMORANDA OF UNDERSTANDING WITH DEPARTMENTS THAT INCUR
17 ADMINISTRATIVE EXPENDITURES RELATED TO THE PROGRAM IDENTIFIED IN
18 SECTION 105D(1).
19 SEC. 105F. (1) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY
20 HEALTH AND THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND
21 FINANCIAL SERVICES SHALL ESTABLISH A MICHIGAN HEALTH CARE COST AND
22 QUALITY ADVISORY COMMITTEE CONSISTING OF 8 OR MORE MEMBERS.
23 (2) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH, OR HIS
24 OR HER DESIGNEE, AND 1 DEPARTMENT OF COMMUNITY HEALTH STAFF MEMBER
25 AND THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCIAL
26 SERVICES, OR HIS OR HER DESIGNEE, AND 1 DEPARTMENT OF INSURANCE AND
27 FINANCIAL SERVICES STAFF MEMBER ARE MEMBERS OF THE COMMITTEE

1 ESTABLISHED IN SUBSECTION (1). THE CHAIRS AND MINORITY VICE CHAIRS
2 OF THE SENATE AND HOUSE HEALTH POLICY COMMITTEES OR THEIR DESIGNEES
3 ARE MEMBERS OF THE COMMITTEE. THE COMMITTEE MEMBERS SHALL ELECT A
4 CHAIRPERSON AND APPOINT ADDITIONAL MEMBERS TO THE ADVISORY
5 COMMITTEE ESTABLISHED IN SUBSECTION (1) NECESSARY TO PERFORM THE
6 DUTIES PRESCRIBED IN THIS SECTION.
7 (3) THE ADVISORY COMMITTEE ESTABLISHED IN SUBSECTION (1) SHALL
8 ISSUE A REPORT BY DECEMBER 31, 2014 WITH RECOMMENDATIONS ON THE
9 CREATION OF A DATABASE ON HEALTH CARE COSTS AND HEALTH CARE QUALITY
10 IN THIS STATE. THIS REPORT SHALL BE TRANSMITTED TO THE LEGISLATURE
11 AND MADE AVAILABLE ON THE DEPARTMENT OF COMMUNITY HEALTH'S AND THE
12 DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES' WEBSITES. THE
13 ADVISORY COMMITTEE SHALL INCLUDE IN THE REPORT AT LEAST ALL OF THE
14 FOLLOWING:
15 (A) A REVIEW OF EXISTING EFFORTS ACROSS THE UNITED STATES TO
16 MAKE HEALTH CARE COST AND QUALITY MORE TRANSPARENT.
17 (B) A REVIEW OF PROPOSED LEGISLATION IN THIS STATE TO MAKE
18 HEALTH CARE COST AND QUALITY MORE TRANSPARENT.
19 (C) A REVIEW OF ANY EXISTING STANDARDS GOVERNING THE OPERATION
20 OF SIMILAR DATABASES.
21 (D) A CONSIDERATION OF BOTH PRICE AND QUALITY OF HEALTH CARE
22 SERVICES RENDERED IN THIS STATE.
23 (E) TRANSPARENCY AND PRIVACY ISSUES.
24 (F) THE POSSIBLE IMPACT OF UNCOMPENSATED CARE ON COMMERCIAL
25 INSURANCE RATES.
26 (G) OTHER METHODS TO ACCURATELY ESTIMATE THE UNCOMPENSATED
27 CARE IMPACT ON COMMERCIAL INSURANCE RATES.

(4) THIS SECTION APPLIES WHETHER OR NOT EITHER OR BOTH OF THE WAIVERS REQUESTED UNDER SECTION 105D ARE APPROVED, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IS REPEALED, OR THE STATE TERMINATES OR OPTS OUT OF THE PROGRAM ESTABLISHED UNDER THIS SECTION.

Sec. 106. (1) A medically indigent individual is defined as:

(a) An individual receiving family independence program benefits or an individual receiving supplemental security income under title XVI or state supplementation under title XVI subject to limitations imposed by the director according to title XIX.

(b) Except as provided in section 106a, an individual who meets all of the following conditions:

(*i*) The individual has applied in the manner the ~~family independence agency~~ **DEPARTMENT OF COMMUNITY HEALTH** prescribes.

(*ii*) The individual's need for the type of medical assistance available under this act for which the individual applied has been professionally established and payment for it is not available through the legal obligation of a public or private contractor to pay or provide for the care without regard to the income or resources of the patient. The state department ~~is~~ **AND THE DEPARTMENT OF COMMUNITY HEALTH ARE** subrogated to any right of recovery that a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the state department **OR THE DEPARTMENT OF COMMUNITY HEALTH** for the care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an

1 assignment of claim or other authorizations as necessary to secure
2 the right of recovery to the department **OR THE DEPARTMENT OF**
3 **COMMUNITY HEALTH**. A payment may be withheld under this act for
4 medical assistance for an injury or disability for which the
5 individual is entitled to medical care or reimbursement for the
6 cost of medical care under sections 3101 to 3179 of the insurance
7 code of 1956, 1956 PA 218, MCL 500.3101 to 500.3179, or under
8 another policy of insurance providing medical or hospital benefits,
9 or both, for the individual unless the individual's entitlement to
10 that medical care or reimbursement is at issue. If a payment is
11 made, the state department **OR THE DEPARTMENT OF COMMUNITY HEALTH**,
12 to enforce its subrogation right, may do either of the following:
13 (a) intervene or join in an action or proceeding brought by the
14 injured, diseased, or disabled individual, the individual's
15 guardian, personal representative, estate, dependents, or
16 survivors, against the third person who may be liable for the
17 injury, disease, or disability, or against contractors, public or
18 private, who may be liable to pay or provide medical care and
19 services rendered to an injured, diseased, or disabled individual;
20 (b) institute and prosecute a legal proceeding against a third
21 person who may be liable for the injury, disease, or disability, or
22 against contractors, public or private, who may be liable to pay or
23 provide medical care and services rendered to an injured, diseased,
24 or disabled individual, in state or federal court, either alone or
25 in conjunction with the injured, diseased, or disabled individual,
26 the individual's guardian, personal representative, estate,
27 dependents, or survivors. The state department may institute the

1 proceedings in its own name or in the name of the injured,
2 diseased, or disabled individual, the individual's guardian,
3 personal representative, estate, dependents, or survivors. As
4 provided in section 6023 of the revised judicature act of 1961,
5 1961 PA 236, MCL 600.6023, the state department **OR THE DEPARTMENT**
6 **OF COMMUNITY HEALTH**, in enforcing its subrogation right, shall not
7 satisfy a judgment against the third person's property that is
8 exempt from levy and sale. The injured, diseased, or disabled
9 individual may proceed in his or her own name, collecting the costs
10 without the necessity of joining the state department**, THE**
11 **DEPARTMENT OF COMMUNITY HEALTH,** or the state as a named party. The
12 injured, diseased, or disabled individual shall notify the state
13 department **OR THE DEPARTMENT OF COMMUNITY HEALTH** of the action or
14 proceeding entered into upon commencement of the action or
15 proceeding. An action taken by the state**,** ~~or~~ the state department**,**
16 **OR THE DEPARTMENT OF COMMUNITY HEALTH** in connection with the right
17 of recovery afforded by this section does not deny the injured,
18 diseased, or disabled individual any part of the recovery beyond
19 the costs expended on the individual's behalf by the state
20 department **OR THE DEPARTMENT OF COMMUNITY HEALTH**. The costs of
21 legal action initiated by the state shall be paid by the state. A
22 payment shall not be made under this act for medical assistance for
23 an injury, disease, or disability for which the individual is
24 entitled to medical care or the cost of medical care under the
25 worker's disability compensation act of 1969, 1969 PA 317, MCL
26 418.101 to 418.941; except that payment may be made if an
27 appropriate application for medical care or the cost of the medical

1 care has been made under the worker's disability compensation act
2 of 1969, 1969 PA 317, MCL 418.101 to 418.941, entitlement has not
3 been finally determined, and an arrangement satisfactory to the
4 state department **OR THE DEPARTMENT OF COMMUNITY HEALTH** has been
5 made for reimbursement if the claim under the worker's disability
6 compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, is
7 finally sustained.
8 (*iii*) The individual has an annual income that is below, or
9 subject to limitations imposed by the director and because of
10 medical expenses falls below, the protected basic maintenance
11 level. The protected basic maintenance level for 1-person and 2-
12 person families shall be at least 100% of the payment standards
13 generally used to determine eligibility in the family independence
14 program. For families of 3 or more persons, the protected basic
15 maintenance level shall be at least 100% of the payment standard
16 generally used to determine eligibility in the family independence
17 program. These levels shall recognize regional variations and shall
18 not exceed 133-1/3% of the payment standard generally used to
19 determine eligibility in the family independence program.
20 (*iv*) The individual, if a family independence program related
21 individual and living alone, has liquid or marketable assets of not
22 more than $2,000.00 in value, or, if a 2-person family, the family
23 has liquid or marketable assets of not more than $3,000.00 in
24 value. The ~~state~~ department **OF COMMUNITY HEALTH** shall establish
25 comparable liquid or marketable asset amounts for larger family
26 groups. Excluded in making the determination of the value of liquid
27 or marketable assets are the values of: the homestead; clothing;

1 household effects; $1,000.00 of cash surrender value of life
2 insurance, except that if the health of the insured makes
3 continuance of the insurance desirable, the entire cash surrender
4 value of life insurance is excluded from consideration, up to the
5 maximum provided or allowed by federal regulations and in
6 accordance with ~~state~~ department **OF COMMUNITY HEALTH** rules; the
7 fair market value of tangible personal property used in earning
8 income; an amount paid as judgment or settlement for damages
9 suffered as a result of exposure to agent orange, as defined in
10 section 5701 of the public health code, 1978 PA 368, MCL 333.5701;
11 and a space or plot purchased for the purposes of burial for the
12 person. For individuals related to the title XVI program, the
13 appropriate resource levels and property exemptions specified in
14 title XVI shall be used.
15 (*v*) The individual is not an inmate of a public institution
16 except as a patient in a medical institution.
17 (*vi*) The individual meets the eligibility standards for
18 supplemental security income under title XVI or for state
19 supplementation under the act, subject to limitations imposed by
20 the director **OF THE DEPARTMENT OF COMMUNITY HEALTH** according to
21 title XIX; or meets the eligibility standards for family
22 independence program benefits; or meets the eligibility standards
23 for optional eligibility groups under title XIX, subject to
24 limitations imposed by the director **OF THE DEPARTMENT OF COMMUNITY**
25 **HEALTH** according to title XIX.
26 **(C) AN INDIVIDUAL IS ELIGIBLE UNDER SECTION**
27 **1396A(A)(10)(A)(I)(VIII) OF TITLE XIX. THIS SUBDIVISION DOES NOT**

1 **APPLY IF EITHER OF THE FOLLOWING OCCURS:**

2 **(*i*) IF THE DEPARTMENT OF COMMUNITY HEALTH IS UNABLE TO OBTAIN A**
3 **FEDERAL WAIVER AS PROVIDED IN SECTION 105D(1) OR (20).**

4 **(*ii*) IF FEDERAL GOVERNMENT MATCHING FUNDS FOR THE PROGRAM**
5 **DESCRIBED IN SECTION 105D ARE REDUCED BELOW 100% AND ANNUAL STATE**
6 **SAVINGS AND OTHER NONFEDERAL NET SAVINGS ASSOCIATED WITH THE**
7 **IMPLEMENTATION OF THAT PROGRAM ARE NOT SUFFICIENT TO COVER THE**
8 **REDUCED FEDERAL MATCH. THE DEPARTMENT OF COMMUNITY HEALTH SHALL**
9 **DETERMINE AND THE STATE BUDGET OFFICE SHALL APPROVE HOW ANNUAL**
10 **STATE SAVINGS AND OTHER NONFEDERAL NET SAVINGS SHALL BE CALCULATED**
11 **BY JUNE 1, 2014. BY SEPTEMBER 1, 2014, THE CALCULATIONS AND**
12 **METHODOLOGY USED TO DETERMINE THE STATE AND OTHER NONFEDERAL NET**
13 **SAVINGS SHALL BE SUBMITTED TO THE LEGISLATURE.**

14 (2) As used in this act:

15 (a) ~~"Medicaid contracted~~ **"CONTRACTED** health plan" means a
16 managed care organization with whom the state department **OR THE**
17 **DEPARTMENT OF COMMUNITY HEALTH** contracts to provide or arrange for
18 the delivery of comprehensive health care services as authorized
19 under this act.

20 **(B) "FEDERAL POVERTY GUIDELINES" MEANS THE POVERTY GUIDELINES**
21 **PUBLISHED ANNUALLY IN THE FEDERAL REGISTER BY THE UNITED STATES**
22 **DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDER ITS AUTHORITY TO**
23 **REVISE THE POVERTY LINE UNDER SECTION 673(2) OF SUBTITLE B OF TITLE**
24 **VI OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981, 42 USC 9902.**

25 **(C)** ~~(b)~~ "Medical institution" means a state licensed or
26 approved hospital, nursing home, medical care facility, psychiatric
27 hospital, or other facility or identifiable unit of a listed

institution certified as meeting established standards for a nursing home or hospital in accordance with the laws of this state.

(D) ~~(c)~~ "Title XVI" means title XVI of the social security act, 42 USC 1381 to ~~1382j and 1383 to~~ 1383f.

(3) An individual receiving medical assistance under this act or his or her legal counsel shall notify the state department **OR THE DEPARTMENT OF COMMUNITY HEALTH** when filing an action in which the state department **OR THE DEPARTMENT OF COMMUNITY HEALTH** may have a right to recover expenses paid under this act. If the individual is enrolled in a ~~medicaid~~ contracted health plan, the individual or his or her legal counsel shall provide notice to the ~~medicaid~~ contracted health plan in addition to providing notice to the state department.

(4) If a legal action in which the state department, **THE DEPARTMENT OF COMMUNITY HEALTH,** a ~~medicaid~~ contracted health plan, or ~~both has~~ **ALL 3 HAVE** a right to recover expenses paid under this act is filed and settled after November 29, 2004 without notice to the state department**, THE DEPARTMENT OF COMMUNITY HEALTH,** or the ~~medicaid~~ contracted health plan, the state department**, THE DEPARTMENT OF COMMUNITY HEALTH,** or the ~~medicaid~~ contracted health plan may file a legal action against the individual or his or her legal counsel, or both, to recover expenses paid under this act. The attorney general shall recover any cost or attorney fees associated with a recovery under this subsection.

(5) The state department **OR THE DEPARTMENT OF COMMUNITY HEALTH** has first priority against the proceeds of the net recovery from the settlement or judgment in an action settled in which notice has

1 been provided under subsection (3). A ~~medicaid~~ contracted health
2 plan has priority immediately after the state department **OR THE**
3 **DEPARTMENT OF COMMUNITY HEALTH** in an action settled in which notice
4 has been provided under subsection (3). The state department**, THE**
5 **DEPARTMENT OF COMMUNITY HEALTH,** and a ~~medicaid~~ contracted health
6 plan shall recover the full cost of expenses paid under this act
7 unless the state department**, THE DEPARTMENT OF COMMUNITY HEALTH,** or
8 the ~~medicaid~~ contracted health plan agrees to accept an amount less
9 than the full amount. If the individual would recover less against
10 the proceeds of the net recovery than the expenses paid under this
11 act, the state department**, THE DEPARTMENT OF COMMUNITY HEALTH,** or
12 ~~medicaid~~ contracted health plan, and the individual shall share
13 equally in the proceeds of the net recovery. As used in this
14 subsection, "net recovery" means the total settlement or judgment
15 less the costs and fees incurred by or on behalf of the individual
16 who obtains the settlement or judgment.
17 Sec. 107. **(1)** In establishing financial eligibility for the
18 medically indigent**,** ~~as defined in section 106,~~ income shall be
19 disregarded in accordance with standards established for the
20 related categorical assistance program. For medical assistance
21 only, income shall include the amount of contribution that an
22 estranged spouse or parent for a minor child is making to the
23 applicant according to the standards of the ~~state~~ department **OF**
24 **COMMUNITY HEALTH**, or according to a court determination, if there
25 is a court determination. Nothing in this section eliminates the
26 responsibility of support established in section 76 for cash
27 assistance received under this act.

1 **(2) THE DEPARTMENT OF COMMUNITY HEALTH SHALL APPLY A MODIFIED**
2 **ADJUSTED GROSS INCOME METHODOLOGY IN DETERMINING IF AN INDIVIDUAL'S**
3 **ANNUAL INCOME LEVEL IS BELOW 133% OF THE FEDERAL POVERTY**
4 **GUIDELINES.**
5 Sec. 108. A medically indigent person as defined under
6 ~~subdivision (1) of~~ section ~~106,~~ **106(1)(A)** is entitled to all the
7 services enumerated in ~~subsections (a), (b), (c), (d), (e) and (f)~~
8 ~~of~~ section 109. A medically indigent person as defined under
9 ~~subdivision (2) of~~ section ~~106~~ **106(1)(B)** is entitled to medical
10 services enumerated in ~~subsections (a), (c) and (e) of section 109.~~
11 **SECTION 109(1)(A), (C), AND (E).** He ~~shall also be~~ **OR SHE IS**
12 entitled to the services enumerated in ~~subsections (b),~~ **SECTION**
13 **109(1)(B),** (d)**,** and (f) ~~of section 109~~ to the extent of
14 appropriations made available by the legislature for the fiscal
15 year. Medical services shall be rendered upon certification by the
16 attending licensed physician and dental services shall be rendered
17 upon certification of the attending licensed dentist that a service
18 is required for the treatment of an individual. The services of a
19 medical institution shall be rendered only after referral by a
20 licensed physician or dentist and certification by him **OR HER** that
21 the services of the medical institution are required for the
22 medical or dental treatment of the individual, except that referral
23 is not necessary in case of an emergency. Periodic recertification
24 that medical treatment ~~which~~ **THAT** extends over a period of time is
25 required in accordance with regulations of the ~~state~~ department
26 ~~shall be~~ **OF COMMUNITY HEALTH IS** a condition of continuing
27 eligibility to receive medical assistance. To comply with federal

statutes governing medicaid, the ~~state~~ department **OF COMMUNITY HEALTH** shall provide ~~such~~ early and periodic screening, diagnostic and treatment services to eligible children as it ~~deems~~ **CONSIDERS** necessary.

Sec. 109c. (1) The ~~state~~ department **OF COMMUNITY HEALTH** shall include, as part of its program of medical services under this act, home- or community-based services to eligible persons whom the ~~state~~ department **OF COMMUNITY HEALTH** determines would otherwise require nursing home services or similar institutional care services under section 109. The home- or community-based services shall be offered to qualified eligible persons who are receiving inpatient hospital or nursing home services as an alternative to those forms of care.

(2) The home- or community-based services shall include safeguards adequate to protect the health and welfare of participating eligible persons, and shall be provided according to a written plan of care for each person. The services available under the home- or community-based services program shall include, at a minimum, all of the following:

(a) Home delivered meals.

(b) Chore services.

(c) Homemaker services.

(d) Respite care.

(e) Personal care.

(f) Adult day care.

(g) Private duty nursing.

(h) Mental health counseling.

(i) Caregiver training.

(j) Emergency response systems.

(k) Home modification.

(*l*) Transportation.

(m) Medical equipment and supply services.

(3) This section shall be implemented so that the average per capita expenditure for home- or community-based services for eligible persons receiving those services does not exceed the estimated average per capita expenditure that would have been made for those persons had they been receiving nursing home services, inpatient hospital or similar institutional care services instead.

(4) The ~~state~~ department **OF COMMUNITY HEALTH** shall seek a waiver necessary to implement this program from the federal department of health and human services, as provided in section 1915 of title XIX, 42 ~~U.S.C.~~ **USC** 1396n. The department **OF COMMUNITY HEALTH** shall request any modifications of the waiver that are necessary in order to expand the program in accordance with subsection (9).

(5) The ~~state~~ department **OF COMMUNITY HEALTH** shall establish policy for identifying the rules for persons receiving inpatient hospital or nursing home services who may qualify for home- or community-based services. The rules shall contain, at a minimum, a listing of diagnoses and patient conditions to which the option of home- or community-based services may apply, and a procedure to determine if the person qualifies for home- or community-based services.

(6) The ~~state~~ department **OF COMMUNITY HEALTH** shall provide to

the legislature and the governor an annual report showing the detail of its home- and community-based case finding and placement activities. At a minimum, the report shall contain each of the following:

(a) The number of persons provided home- or community-based services who would otherwise require inpatient hospital services. This shall include a description of medical conditions, services provided, and projected cost savings for these persons.

(b) The number of persons provided home- or community-based services who would otherwise require nursing home services. This shall include a description of medical conditions, services provided, and projected cost savings for these persons.

(c) The number of persons and the annual expenditure for personal care services.

(d) The number of hearings requested concerning home- or community-based services and the outcome of each hearing which has been adjudicated during the year.

(7) The written plan of care required under subsection (2) for an eligible person shall not be changed unless the change is prospective only, and the ~~state~~ department **OF COMMUNITY HEALTH** does both of the following:

(a) Not later than 30 days before making the change, except in the case of emergency, consults with the eligible person or, in the case of a child, with the child's parent or guardian.

(b) Consults with each medical service provider involved in the change. This consultation shall be documented in writing.

(8) An eligible person who is receiving home- or community-

based services under this section, and who is dissatisfied with a change in his or her plan of care or a denial of any home- or community-based service, may demand a hearing as provided in section 9, and subsequently may appeal the hearing decision to circuit court as provided in section 37.

(9) The ~~state~~ department **OF COMMUNITY HEALTH** shall expand the home- and community-based services program by increasing the number of counties in which it is available, in conformance with this subsection. The program may be limited in total cost and in the number of recipients per county who may receive services at 1 time. Subject to obtaining the waiver and any modifications of the waiver sought under subsection (4), the program shall be expanded as follows:

(a) Not later than ~~1 year after the effective date of this subsection,~~ **JULY 14, 1995,** home- and community-based services shall be available to eligible applicants in those counties that, when combined, contain at least 1/4 of the population of this state.

(b) Not later than ~~2 years after the effective date of this subsection,~~ **JULY 14, 1996,** home- and community-based services shall be available to eligible applicants in those counties that, when combined, contain at least 1/2 of the population of this state.

(c) Not later than ~~3 years after the effective date of this subsection,~~ **JULY 14, 1997,** home- and community-based services shall be available to eligible applicants in those counties that, when combined, contain at least 3/4 of the population of this state.

(d) Not later than ~~4 years after the effective date of this subsection,~~ **JULY 14, 1998,** home- and community-based services shall

be available to eligible applicants on a statewide basis.

(10) The ~~state~~ department **OF COMMUNITY HEALTH** shall work with the office of services to the aging in implementing the home- and community-based services program, including the provision of preadmission screening, case management, and recipient access to services.

Enacting section 1. This amendatory act does not do either of the following:

(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange.