THE SOCIAL WELFARE ACT (EXCERPT)
Act 280 of 1939

400.109 Medical services provided under act; notice and approval of proposed change in method or level of reimbursement; definitions.

Sec. 109. (1) An eligible individual may receive the following medical services under this act:

(a) Hospital services that an eligible individual may receive consist of medical, surgical, or obstetrical care, together with necessary drugs, X-rays, physical therapy, prosthesis, transportation, and nursing care incident to the medical, surgical, or obstetrical care. The period of inpatient hospital service shall be the minimum period necessary in this type of facility for the proper care and treatment of the individual. Necessary hospitalization to provide dental care must be provided if certified by the attending dentist with the approval of the department. An individual who is receiving medical treatment as an inpatient because of a diagnosis of mental disease may receive service under this section, notwithstanding the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106. The department must pay for hospital services according to the state plan for medical assistance adopted under section 10 and approved by the United States Department of Health and Human Services.

(b) Physicians services authorized by the department. The services may be furnished in the physician's office, the eligible individual's home, a medical institution, or elsewhere in case of emergency. A physician must be paid a reasonable charge for the service rendered. The department must determine reasonable charges. Reasonable charges must not be more than those paid in this state for services rendered under title XVIII.

(c) Nursing home services in a state licensed nursing home, a medical care facility, or other facility or identifiable unit of that facility, certified by the appropriate authority as meeting established standards for a nursing home under the laws and rules of this state and the United States Department of Health and Human Services, to the extent found necessary by the attending physician, dentist, or certified Christian Science practitioner. An eligible individual may receive nursing home services in an extended care services program established under section 22210 of the public health code, 1978 PA 368, MCL 333.22210, to the extent found necessary by the attending physician when the combined length of stay in the acute care bed and short-term nursing care bed exceeds the average length of stay for Medicaid hospital diagnostic related group reimbursement. The department shall not make a final payment under title XIX for benefits available under title XVIII without documentation that title XVIII claims have been filed and denied. The department must pay for nursing home services according to the state plan for medical assistance adopted according to section 10 and approved by the United States Department of Health and Human Services. A county must reimburse a county maintenance of effort rate determined on an annual basis for each patient day of Medicaid nursing home services provided to eligible individuals in long-term care facilities owned by the county and licensed to provide nursing home services. For purposes of determining rates and costs described in this subdivision, all of the following apply:

(*i*) For county-owned facilities with per patient day updated variable costs exceeding the variable cost limit for the county facility, county maintenance of effort rate means 45% of the difference between per patient day updated variable cost and the concomitant nursing home-class variable cost limit, the quantity offset by the difference between per patient day updated variable cost and the concomitant variable cost limit for the county facility. The county rate must not be less than zero.

(*ii*) For county-owned facilities with per patient day updated variable costs not exceeding the variable cost limit for the county facility, county maintenance of effort rate means 45% of the difference between per patient day updated variable cost and the concomitant nursing home class variable cost limit.

(*iii*) For county-owned facilities with per patient day updated variable costs not exceeding the concomitant nursing home class variable cost limit, the county maintenance of effort rate must equal zero.

(*iv*) For the purposes of this section: "per patient day updated variable costs and the variable cost limit for the county facility" must be determined according to the state plan for medical assistance; for freestanding county facilities the "nursing home class variable cost limit" must be determined according to the state plan for medical assistance and for hospital attached county facilities the "nursing class variable cost limit" must be determined according to the state plan for medical assistance plus $5.00 per patient day; and "freestanding" and "hospital attached" must be determined according to the federal regulations.

(*v*) If the county maintenance of effort rate computed under this section exceeds the county maintenance of effort rate in effect as of September 30, 1984, the rate in effect as of September 30, 1984 must remain in effect until a time that the rate computed under this section is less than the September 30, 1984 rate. This limitation remains in effect until December 31, 2025 or until a new reimbursement system determined by the department replaces the current system, whichever is sooner. For each subsequent county fiscal year, the

maintenance of effort rate may not increase by more than $1.00 per patient day each year.

(*vi*) For county-owned facilities, reimbursement for plant costs must continue to be based on interest expense and depreciation allowance unless otherwise provided by law.

(d) Pharmaceutical services from a licensed pharmacist of the individual's choice as prescribed by a licensed physician or dentist and approved by the department. In an emergency, but not routinely, the individual may receive pharmaceutical services rendered personally by a licensed physician or dentist on the same basis as approved for pharmacists.

(e) Other medical and health services as authorized by the department.

(f) Psychiatric care according to the guidelines established by the department to the extent of appropriations made available by the legislature for the fiscal year.

(g) Screening, laboratory services, diagnostic services, early intervention services, and treatment for chronic kidney disease under guidelines established by the department. A clinical laboratory performing a creatinine test on an eligible individual under this subdivision must include in the lab report the glomerular filtration rate (eGFR) of the individual and must report it as a percentage of kidney function remaining.

(h) Medically necessary acute medical detoxification for opioid use disorder, medically necessary inpatient care at an approved facility, or care in an appropriately licensed substance use disorder residential treatment facility.

(i) Mental health screenings during the postpartum period as described in section 9137 of the public health code, 1978 PA 368, MCL 333.9137.

(2) The director must provide notice to the public, according to applicable federal regulations, and must obtain the approval of the committees on appropriations of the house of representatives and senate of the state legislature, of a proposed change in the statewide method or level of reimbursement for a service, if the proposed change is expected to increase or decrease payments for that service by 1% or more during the 12 months after the effective date of the change.

(3) As used in this act:

(a) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-7.

(c) "Title XX" means title XX of the social security act, 42 USC 1397 to 1397n-13.

History: Add. 1966, Act 321, Eff. Oct. 1, 1966;—Am. 1967, Act 289, Imd. Eff. Aug. 1, 1967;—Am. 1970, Act 160, Imd. Eff. Aug. 2, 1970;—Am. 1972, Act 367, Imd. Eff. Jan. 9, 1973;—Am. 1977, Act 79, Imd. Eff. Aug. 2, 1977;—Am. 1980, Act 321, Imd. Eff. Dec. 12, 1980;—Am. 1980, Act 391, Imd. Eff. Jan. 7, 1981;—Am. 1984, Act 408, Imd. Eff. Dec. 28, 1984;—Am. 1990, Act 193, Imd. Eff. July 24, 1990;—Am. 1990, Act 261, Imd. Eff. Oct. 15, 1990;—Am. 1994, Act 352, Imd. Eff. Dec. 22, 1994;—Am. 1995, Act 277, Imd. Eff. Jan. 8, 1996;—Am. 1996, Act 473, Imd. Eff. Dec. 26, 1996;—Am. 1997, Act 173, Imd. Eff. Dec. 30, 1997;—Am. 2000, Act 168, Imd. Eff. June 20, 2000;—Am. 2002, Act 673, Imd. Eff. Dec. 26, 2002;—Am. 2006, Act 327, Imd. Eff. Aug. 10, 2006;—Am. 2006, Act 576, Imd. Eff. Jan. 3, 2007;—Am. 2011, Act 53, Imd. Eff. June 8, 2011;—Am. 2012, Act 48, Imd. Eff. Mar. 13, 2012;—Am. 2016, Act 551, Eff. Apr. 10, 2017;—Am. 2017, Act 253, Eff. Mar. 27, 2018;—Am. 2018, Act 315, Imd. Eff. June 29, 2018;—Am. 2022, Act 98, Imd. Eff. June 14, 2022;—Am. 2024, Act 248, Eff. Apr. 2, 2025.

Compiler's note: For transfer of powers and duties of the home help program and the physical disabilities program from the family independence agency to the director of the department of community health, see E.R.O. No. 1997-5, compiled at MCL 400.224 of the Michigan Compiled Laws.

Popular name: Act 280