

**SUBSTITUTE FOR  
HOUSE BILL NO. 4404**

A bill to amend 1978 PA 368, entitled "Public health code," by amending sections 20106, 20109, 20115, 20142, and 20161 (MCL 333.20106, 333.20109, 333.20115, 333.20142, and 333.20161), section 20106 as amended by 2017 PA 167, section 20109 as amended by 2015 PA 156, section 20115 as amended by 2012 PA 499, and section 20161 as amended by 2016 PA 189, and by adding part 218.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

1           Sec. 20106. (1) "Health facility or agency", except as  
2 provided in section 20115, means:

3           (a) An ambulance operation, aircraft transport operation,  
4 nontransport prehospital life support operation, or medical first  
5 response service.

6           (b) A county medical care facility.

- 1 (c) A freestanding surgical outpatient facility.  
2 (d) A health maintenance organization.  
3 (e) A home for the aged.  
4 (f) A hospital.  
5 (g) A nursing home.  
6 (h) A hospice.  
7 (i) A hospice residence.  
8 (j) A facility or agency listed in subdivisions (a) to (g)  
9 located in a university, college, or other educational institution.

10 **(K) A PAIN MANAGEMENT FACILITY.**

11 (2) "Health maintenance organization" means that term as  
12 defined in section 3501 of the insurance code of 1956, 1956 PA 218,  
13 MCL 500.3501.

14 (3) "Home for the aged" means a supervised personal care  
15 facility at a single address, other than a hotel, adult foster care  
16 facility, hospital, nursing home, or county medical care facility  
17 that provides room, board, and supervised personal care to 21 or  
18 more unrelated, nontransient, individuals 55 years of age or older.  
19 Home for the aged includes a supervised personal care facility for  
20 20 or fewer individuals 55 years of age or older if the facility is  
21 operated in conjunction with and as a distinct part of a licensed  
22 nursing home. Home for the aged does not include an area excluded  
23 from this definition by section 17(3) of the continuing care  
24 community disclosure act, 2014 PA 448, MCL 554.917.

25 (4) "Hospice" means a health care program that provides a  
26 coordinated set of services rendered at home or in outpatient or  
27 institutional settings for individuals suffering from a disease or

1 condition with a terminal prognosis.

2 (5) "Hospital" means a facility offering inpatient, overnight  
3 care, and services for observation, diagnosis, and active treatment  
4 of an individual with a medical, surgical, obstetric, chronic, or  
5 rehabilitative condition requiring the daily direction or  
6 supervision of a physician. Hospital does not include a mental  
7 health hospital licensed or operated by the department of health  
8 and human services or a hospital operated by the department of  
9 corrections.

10 (6) "Hospital long-term care unit" means a nursing care  
11 facility, owned and operated by and as part of a hospital,  
12 providing organized nursing care and medical treatment to 7 or more  
13 unrelated individuals suffering or recovering from illness, injury,  
14 or infirmity.

15 Sec. 20109. (1) "Nursing home" means a nursing care facility,  
16 including a county medical care facility, that provides organized  
17 nursing care and medical treatment to 7 or more unrelated  
18 individuals suffering or recovering from illness, injury, or  
19 infirmity. As used in this subsection, "medical treatment" includes  
20 treatment by an employee or independent contractor of the nursing  
21 home who is an individual licensed or otherwise authorized to  
22 engage in a health profession under part 170 or 175. Nursing home  
23 does not include any of the following:

24 (a) A unit in a state correctional facility.

25 (b) A hospital.

26 (c) A veterans facility created under 1885 PA 152, MCL 36.1 to  
27 36.12.

1 (d) A hospice residence that is licensed under this article.

2 (e) A hospice that is certified under 42 CFR 418.100.

3 **(2) "PAIN MANAGEMENT FACILITY" MEANS THAT TERM AS DEFINED IN**  
4 **SECTION 21805.**

5 **(3)** ~~(2)~~—"Person" means that term as defined in section 1106 or  
6 a governmental entity.

7 **(4)** ~~(3)~~—"Public member" means a member of the general public  
8 who is not a provider; who does not have an ownership interest in  
9 or contractual relationship with a nursing home other than a  
10 resident contract; who does not have a contractual relationship  
11 with a person who does substantial business with a nursing home;  
12 and who is not the spouse, parent, sibling, or child of an  
13 individual who has an ownership interest in or contractual  
14 relationship with a nursing home, other than a resident contract.

15 **(5)** ~~(4)~~—"Skilled nursing facility" means a hospital long-term  
16 care unit, nursing home, county medical care facility, or other  
17 nursing care facility, or a distinct part thereof, certified by the  
18 department to provide skilled nursing care.

19 Sec. 20115. (1) The department may promulgate rules to further  
20 define the term "health facility or agency" and the definition of a  
21 health facility or agency listed in section 20106 as required to  
22 implement this article. The department may define a specific  
23 organization as a health facility or agency for the sole purpose of  
24 certification authorized under this article. For purpose of  
25 certification only, an organization defined in section 20106(5),  
26 20108(1), or ~~20109(4)~~ **20109(5)** is considered a health facility or  
27 agency. The term "health facility or agency" does not mean a

1 visiting nurse service or home aide service conducted by and for  
2 the adherents of a church or religious denomination for the purpose  
3 of providing service for those who depend upon spiritual means  
4 through prayer alone for healing.

5 (2) The department shall promulgate rules to differentiate a  
6 freestanding surgical outpatient facility from a private office of  
7 a physician, dentist, podiatrist, or other health professional. The  
8 department shall specify in the rules that a facility including,  
9 but not limited to, a private practice office described in this  
10 subsection must be licensed under this article as a freestanding  
11 surgical outpatient facility if that facility performs 120 or more  
12 surgical abortions per year and publicly advertises outpatient  
13 abortion services.

14 (3) The department shall promulgate rules that in effect  
15 republish R 325.3826, R 325.3832, R 325.3835, R 325.3857, R  
16 325.3866, R 325.3867, and R 325.3868 of the Michigan ~~administrative~~  
17 ~~code~~, **ADMINISTRATIVE CODE**, but shall include in the rules standards  
18 for a freestanding surgical outpatient facility or private practice  
19 office that performs 120 or more surgical abortions per year and  
20 that publicly advertises outpatient abortion services. The  
21 department shall ~~assure~~ **ENSURE** that the standards are consistent  
22 with the most recent United States ~~supreme court~~ **SUPREME COURT**  
23 decisions regarding state regulation of abortions.

24 (4) Subject to section 20145 and part 222, the department may  
25 modify or waive 1 or more of the rules contained in R 325.3801 to R  
26 325.3877 of the Michigan ~~administrative code~~ **ADMINISTRATIVE CODE**  
27 regarding construction or equipment standards, or both, for a

1 freestanding surgical outpatient facility that performs 120 or more  
2 surgical abortions per year and that publicly advertises outpatient  
3 abortion services, if both of the following conditions are met:

4 (a) The freestanding surgical outpatient facility was in  
5 existence and operating on December 31, 2012.

6 (b) The department makes a determination that the existing  
7 construction or equipment conditions, or both, within the  
8 freestanding surgical outpatient facility are adequate to preserve  
9 the health and safety of the patients and employees of the  
10 freestanding surgical outpatient facility or that the construction  
11 or equipment conditions, or both, can be modified to adequately  
12 preserve the health and safety of the patients and employees of the  
13 freestanding surgical outpatient facility without meeting the  
14 specific requirements of the rules.

15 (5) By January 15 each year, the department of ~~community~~  
16 health **AND HUMAN SERVICES** shall provide the following information  
17 to the department: ~~of licensing and regulatory affairs:~~

18 (a) From data received by the department of ~~community~~-health  
19 **AND HUMAN SERVICES** through the abortion reporting requirements of  
20 section 2835, all of the following:

21 (i) The name and location of each facility at which abortions  
22 were performed during the immediately preceding calendar year.

23 (ii) The total number of abortions performed at that facility  
24 location during the immediately preceding calendar year.

25 (iii) The total number of surgical abortions performed at that  
26 facility location during the immediately preceding calendar year.

27 (b) Whether a facility at which surgical abortions were

1 performed in the immediately preceding calendar year publicly  
2 advertises abortion services.

3 (6) As used in this section:

4 (a) "Abortion" means that term as defined in section 17015.

5 (b) "Publicly advertises" means to advertise using directory  
6 or internet advertising including yellow pages, white pages, banner  
7 advertising, or electronic publishing.

8 (c) "Surgical abortion" means an abortion that is not a  
9 medical abortion as that term is defined in section 17017.

10 Sec. 20142. (1) A health facility or agency shall apply for  
11 licensure or certification on a form authorized and provided by the  
12 department. The application ~~shall~~**MUST** include attachments,  
13 additional data, and information required **UNDER THIS ARTICLE AND** by  
14 the department.

15 (2) An applicant shall certify the accuracy of information  
16 supplied in the application and supplemental statements.

17 (3) An applicant or a licensee under part 213, ~~or~~ 217, **OR 218**  
18 shall disclose the names, addresses, principal occupations, and  
19 official positions of all persons who have an ownership interest in  
20 the health facility or agency. If the health facility or agency is  
21 located on or in leased real estate, the applicant or licensee  
22 shall disclose the name of the lessor and any direct or indirect  
23 interest the applicant or licensee has in the lease other than as  
24 lessee. A change in ownership ~~shall~~**MUST** be reported to the  
25 director not less than 15 days before the change occurs, except  
26 that a person purchasing stock of a company registered pursuant to  
27 the securities exchange act of 1934, 15 U.S.C. ~~78a to 78kk~~, **USC 78A**

1 ~~TO 78QQ~~, is exempt from disclosing ownership in the facility. A  
 2 person required to file a beneficial ownership report pursuant to  
 3 section ~~16(a)-78P~~ of the securities exchange act of 1934, 15 U.S.C.  
 4 ~~78p-USC 78P~~, shall file with the department information relating to  
 5 securities ownership required by the department rule or order. An  
 6 applicant or licensee proposing a sale of a nursing home to another  
 7 person shall provide the department with written, advance notice of  
 8 the proposed sale. The applicant or licensee and the other parties  
 9 to the sale shall arrange to meet with specified department  
 10 representatives and shall obtain before the sale a determination of  
 11 the items of noncompliance with applicable law and rules ~~which~~  
 12 ~~shall~~ **THAT MUST** be corrected. The department shall notify the  
 13 respective parties of the items of noncompliance ~~prior to~~ **BEFORE**  
 14 the change of ownership and shall indicate that the items of  
 15 noncompliance must be corrected as a condition of issuance of a  
 16 license to the new owner. The department may accept reports filed  
 17 with the ~~securities and exchange commission~~ **UNITED STATES**  
 18 **SECURITIES AND EXCHANGE COMMISSION** relating to the filings. A  
 19 person who violates this subsection is guilty of a misdemeanor,  
 20 punishable by a fine of not more than \$1,000.00 for each violation.

21 (4) An applicant or licensee under part 217 shall disclose the  
 22 names and business addresses of suppliers who furnish goods or  
 23 services to an individual nursing home or a group of nursing homes  
 24 under common ownership, the aggregate charges for which exceed  
 25 \$5,000.00 in a 12-month period ~~which~~ **THAT** includes a month in a  
 26 nursing home's current fiscal year. An applicant or licensee shall  
 27 disclose the names, addresses, principal occupations, and official



1 positions of all persons ~~who~~ **THAT** have an ownership interest in a  
2 business ~~which~~ **THAT** furnishes goods or services to an individual  
3 nursing home or to a group of nursing homes under common ownership,  
4 if both of the following apply:

5 (a) The person, or the person's spouse, parent, sibling, or  
6 child, has an ownership interest in the nursing home purchasing the  
7 goods or services.

8 (b) The aggregate charges for the goods or services purchased  
9 exceeds \$5,000.00 in a 12-month period ~~which~~ **THAT** includes a month  
10 in the nursing home's current fiscal year.

11 (5) An applicant or licensee who makes a false statement in an  
12 application or statement required by the department ~~pursuant to~~  
13 **UNDER** this article is guilty of a felony ~~punishable by~~  
14 imprisonment for not more than 4 years ~~or~~ a fine of not more than  
15 \$30,000.00, or both.

16 Sec. 20161. (1) The department shall assess fees and other  
17 assessments for health facility and agency licenses and  
18 certificates of need on an annual basis as provided in this  
19 article. Until October 1, 2019, except as otherwise provided in  
20 this article, fees and assessments ~~shall~~ **MUST** be paid as provided  
21 in the following schedule:

- 22 (a) Freestanding surgical
- 23 outpatient facilities.....\$500.00 per facility
- 24 license.
- 25 (b) Hospitals.....\$500.00 per facility
- 26 license and \$10.00 per
- 27 licensed bed.

1 (c) Nursing homes, county  
2 medical care facilities, and  
3 hospital long-term care units.....\$500.00 per facility  
4 license and \$3.00 per  
5 licensed bed over 100  
6 licensed beds.

7 (d) Homes for the aged.....\$6.27 per licensed bed.

8 (e) Hospice agencies.....\$500.00 per agency license.

9 (f) Hospice residences.....\$500.00 per facility  
10 license and \$5.00 per  
11 licensed bed.

12 **(G) PAIN MANAGEMENT FACILITIES..\$1,000.00 PER FACILITY**  
13 **LICENSE.**

14 **(H)** ~~(g)~~—Subject to subsection  
15 (11), quality assurance assessment  
16 for nursing homes and hospital  
17 long-term care units.....an amount resulting  
18 in not more than 6%  
19 of total industry  
20 revenues.

21 **(I)** ~~(h)~~—Subject to subsection  
22 (12), quality assurance assessment  
23 for hospitals.....at a fixed or variable  
24 rate that generates  
25 funds not more than the  
26 maximum allowable under  
27 the federal matching

1 requirements, after  
2 consideration for the  
3 amounts in subsection  
4 (12) (a) and (i).

5 (J) ~~(i)~~ Initial licensure  
6 application fee for subdivisions  
7 (a), (b), (c), (e), ~~and~~ (f), \$2,000.00 per initial  
8 **AND (G)**.....license.

9 (2) If a hospital requests the department to conduct a  
10 certification survey for purposes of title XVIII or title XIX, ~~of~~  
11 ~~the social security act,~~ the hospital shall pay a license fee  
12 surcharge of \$23.00 per bed. As used in this subsection, "title  
13 XVIII" and "title XIX" mean those terms as defined in section  
14 20155.

15 (3) All of the following apply to the assessment under this  
16 section for certificates of need:

17 (a) The base fee for a certificate of need is \$3,000.00 for  
18 each application. For a project requiring a projected capital  
19 expenditure of more than \$500,000.00 but less than \$4,000,000.00,  
20 an additional fee of \$5,000.00 is added to the base fee. For a  
21 project requiring a projected capital expenditure of \$4,000,000.00  
22 or more but less than \$10,000,000.00, an additional fee of  
23 \$8,000.00 is added to the base fee. For a project requiring a  
24 projected capital expenditure of \$10,000,000.00 or more, an  
25 additional fee of \$12,000.00 is added to the base fee.

26 (b) In addition to the fees under subdivision (a), the  
27 applicant shall pay \$3,000.00 for any designated complex project

1 including a project scheduled for comparative review or for a  
2 consolidated licensed health facility application for acquisition  
3 or replacement.

4 (c) If required by the department, the applicant shall pay  
5 \$1,000.00 for a certificate of need application that receives  
6 expedited processing at the request of the applicant.

7 (d) The department shall charge a fee of \$500.00 to review any  
8 letter of intent requesting or resulting in a waiver from  
9 certificate of need review and any amendment request to an approved  
10 certificate of need.

11 (e) A health facility or agency that offers certificate of  
12 need covered clinical services shall pay \$100.00 for each  
13 certificate of need approved covered clinical service as part of  
14 the certificate of need annual survey at the time of submission of  
15 the survey data.

16 (f) The department shall use the fees collected under this  
17 subsection only to fund the certificate of need program. Funds  
18 remaining in the certificate of need program at the end of the  
19 fiscal year ~~shall~~**DO** not lapse to the general fund but ~~shall~~ remain  
20 available to fund the certificate of need program in subsequent  
21 years.

22 (4) A license issued under this part is effective for no  
23 longer than 1 year after the date of issuance.

24 (5) Fees described in this section are payable to the  
25 department at the time an application for a license, permit, or  
26 certificate is submitted. If an application for a license, permit,  
27 or certificate is denied or if a license, permit, or certificate is

1 revoked before its expiration date, the department shall not refund  
2 fees paid to the department.

3 (6) The fee for a provisional license or temporary permit is  
4 the same as for a license. A license may be issued at the  
5 expiration date of a temporary permit without an additional fee for  
6 the balance of the period for which the fee was paid if the  
7 requirements for licensure are met.

8 (7) The cost of licensure activities ~~shall~~**MUST** be supported  
9 by license fees.

10 (8) The application fee for a waiver under section 21564 is  
11 \$200.00 plus \$40.00 per hour for the professional services and  
12 travel expenses directly related to processing the application. The  
13 travel expenses ~~shall be~~**ARE** calculated in accordance with the  
14 state standardized travel regulations of the department of  
15 technology, management, and budget in effect at the time of the  
16 travel.

17 (9) An applicant for licensure or renewal of licensure under  
18 part 209 shall pay the applicable fees set forth in part 209.

19 (10) Except as otherwise provided in this section, **THE**  
20 **DEPARTMENT SHALL DEPOSIT** the fees and assessments collected under  
21 this section ~~shall be deposited~~ in the state treasury, to the  
22 credit of the general fund. The department may use the unreserved  
23 fund balance in fees and assessments for the criminal history check  
24 program required under this article.

25 (11) The quality assurance assessment collected under  
26 subsection ~~(1)(g)~~**(1)(H)** and all federal matching funds attributed  
27 to that assessment ~~shall~~**MUST** be used only for the following

1 purposes and under the following specific circumstances:

2 (a) The quality assurance assessment and all federal matching  
3 funds attributed to that assessment ~~shall~~**MUST** be used to finance  
4 Medicaid nursing home reimbursement payments. Only licensed nursing  
5 homes and hospital long-term care units that are assessed the  
6 quality assurance assessment and participate in the Medicaid  
7 program are eligible for increased per diem Medicaid reimbursement  
8 rates under this subdivision. A nursing home or long-term care unit  
9 that is assessed the quality assurance assessment and that does not  
10 pay the assessment required under subsection ~~(1)(g)~~**(1)(H)** in  
11 accordance with subdivision (c) (i) or in accordance with a written  
12 payment agreement with this state shall not receive the increased  
13 per diem Medicaid reimbursement rates under this subdivision until  
14 all of its outstanding quality assurance assessments and any  
15 penalties assessed under subdivision (f) have been paid in full.  
16 This subdivision does not authorize or require the department to  
17 overspend tax revenue in violation of the management and budget  
18 act, 1984 PA 431, MCL 18.1101 to 18.1594.

19 (b) Except as otherwise provided under subdivision (c),  
20 beginning October 1, 2005, the quality assurance assessment is  
21 based on the total number of patient days of care each nursing home  
22 and hospital long-term care unit provided to non-Medicare patients  
23 within the immediately preceding year, ~~shall~~**MUST** be assessed at a  
24 uniform rate on October 1, 2005 and subsequently on October 1 of  
25 each following year, and is payable on a quarterly basis, with the  
26 first payment due 90 days after the date the assessment is  
27 assessed.

1 (c) Within 30 days after September 30, 2005, the department  
2 shall submit an application to the federal Centers for Medicare and  
3 Medicaid Services to request a waiver according to 42 CFR 433.68(e)  
4 to implement this subdivision as follows:

5 (i) If the waiver is approved, the quality assurance  
6 assessment rate for a nursing home or hospital long-term care unit  
7 with less than 40 licensed beds or with the maximum number, or more  
8 than the maximum number, of licensed beds necessary to secure  
9 federal approval of the application is \$2.00 per non-Medicare  
10 patient day of care provided within the immediately preceding year  
11 or a rate as otherwise altered on the application for the waiver to  
12 obtain federal approval. If the waiver is approved, for all other  
13 nursing homes and long-term care units the quality assurance  
14 assessment rate is to be calculated by dividing the total statewide  
15 maximum allowable assessment permitted under subsection ~~(1)(g)~~  
16 **(1)(H)** less the total amount to be paid by the nursing homes and  
17 long-term care units with less than 40 licensed beds or with the  
18 maximum number, or more than the maximum number, of licensed beds  
19 necessary to secure federal approval of the application by the  
20 total number of non-Medicare patient days of care provided within  
21 the immediately preceding year by those nursing homes and long-term  
22 care units with more than 39 licensed beds, but less than the  
23 maximum number of licensed beds necessary to secure federal  
24 approval. The quality assurance assessment, as provided under this  
25 subparagraph, ~~shall~~ **MUST** be assessed in the first quarter after  
26 federal approval of the waiver and ~~shall~~ **MUST** be subsequently  
27 assessed on October 1 of each following year, and is payable on a

1 quarterly basis, with the first payment due 90 days after the date  
2 the assessment is assessed.

3 (ii) If the waiver is approved, continuing care retirement  
4 centers are exempt from the quality assurance assessment if the  
5 continuing care retirement center requires each center resident to  
6 provide an initial life interest payment of \$150,000.00, on  
7 average, per resident to ensure payment for that resident's  
8 residency and services and the continuing care retirement center  
9 utilizes all of the initial life interest payment before the  
10 resident becomes eligible for medical assistance under the state's  
11 Medicaid plan. As used in this subparagraph, "continuing care  
12 retirement center" means a nursing care facility that provides  
13 independent living services, assisted living services, and nursing  
14 care and medical treatment services, in a campus-like setting that  
15 has shared facilities or common areas, or both.

16 (d) Beginning May 10, 2002, the department shall increase the  
17 per diem nursing home Medicaid reimbursement rates for the balance  
18 of that year. For each subsequent year in which the quality  
19 assurance assessment is assessed and collected, the department  
20 shall maintain the Medicaid nursing home reimbursement payment  
21 increase financed by the quality assurance assessment.

22 (e) The department shall implement this section in a manner  
23 that complies with federal requirements necessary to ensure that  
24 the quality assurance assessment qualifies for federal matching  
25 funds.

26 (f) If a nursing home or a hospital long-term care unit fails  
27 to pay the assessment required by subsection ~~(1)(g)~~, **(1)(H)**, the



1 department may assess the nursing home or hospital long-term care  
2 unit a penalty of 5% of the assessment for each month that the  
3 assessment and penalty are not paid up to a maximum of 50% of the  
4 assessment. The department may also refer for collection to the  
5 department of treasury past due amounts consistent with section 13  
6 of 1941 PA 122, MCL 205.13.

7 (g) The Medicaid nursing home quality assurance assessment  
8 fund is established in the state treasury. The department shall  
9 deposit the revenue raised through the quality assurance assessment  
10 with the state treasurer for deposit in the Medicaid nursing home  
11 quality assurance assessment fund.

12 (h) The department shall not implement this subsection in a  
13 manner that conflicts with 42 USC 1396b(w).

14 (i) The **DEPARTMENT SHALL PRORATE THE** quality assurance  
15 assessment collected under subsection ~~(1)(g)~~ shall be prorated  
16 **(1)(H)** on a quarterly basis for any licensed beds added to or  
17 subtracted from a nursing home or hospital long-term care unit  
18 since the immediately preceding July 1. Any adjustments in payments  
19 are due on the next quarterly installment due date.

20 (j) In each fiscal year governed by this subsection, Medicaid  
21 reimbursement rates shall **MUST** not be reduced below the Medicaid  
22 reimbursement rates in effect on April 1, 2002 as a direct result  
23 of the quality assurance assessment collected under subsection  
24 ~~(1)(g)~~. **(1)(H)**.

25 (k) The state retention amount of the quality assurance  
26 assessment collected under subsection ~~(1)(g)~~ shall be **(1)(H) IS**  
27 equal to 13.2% of the federal funds generated by the nursing homes

1 and hospital long-term care units quality assurance assessment,  
 2 including the state retention amount. The state retention amount  
 3 ~~shall~~**MUST** be appropriated each fiscal year to the department to  
 4 support Medicaid expenditures for long-term care services. These  
 5 funds ~~shall~~**MUST** offset an identical amount of general fund/general  
 6 purpose revenue originally appropriated for that purpose.

7 (l) Beginning October 1, 2019, the department shall not assess  
 8 or collect the quality assurance assessment or apply for federal  
 9 matching funds. The **DEPARTMENT SHALL NOT ASSESS OR COLLECT THE**  
 10 quality assurance assessment collected under subsection ~~(1)(g)~~  
 11 ~~shall not be assessed or collected~~ **(1)(H)** after September 30, 2011  
 12 if the quality assurance assessment is not eligible for federal  
 13 matching funds. Any portion of the quality assurance assessment  
 14 collected from a nursing home or hospital long-term care unit that  
 15 is not eligible for federal matching funds ~~shall~~**MUST** be returned  
 16 to the nursing home or hospital long-term care unit.

17 (12) The quality assurance dedication is an earmarked  
 18 assessment collected under subsection ~~(1)(h)~~ **(1)(I)**. That  
 19 assessment and all federal matching funds attributed to that  
 20 assessment ~~shall~~**MUST** be used only for the following purpose and  
 21 under the following specific circumstances:

22 (a) To maintain the increased Medicaid reimbursement rate  
 23 increases as provided for in subdivision (c).

24 (b) The quality assurance assessment ~~shall~~**MUST** be assessed on  
 25 all net patient revenue, before deduction of expenses, less  
 26 Medicare net revenue, as reported in the most recently available  
 27 Medicare cost report and is payable on a quarterly basis, with the

1 first payment due 90 days after the date the assessment is  
2 assessed. As used in this subdivision, "Medicare net revenue"  
3 includes Medicare payments and amounts collected for coinsurance  
4 and deductibles.

5 (c) Beginning October 1, 2002, the department shall increase  
6 the hospital Medicaid reimbursement rates for the balance of that  
7 year. For each subsequent year in which the quality assurance  
8 assessment is assessed and collected, the department shall maintain  
9 the hospital Medicaid reimbursement rate increase financed by the  
10 quality assurance assessments.

11 (d) The department shall implement this section in a manner  
12 that complies with federal requirements necessary to ensure that  
13 the quality assurance assessment qualifies for federal matching  
14 funds.

15 (e) If a hospital fails to pay the assessment required by  
16 subsection ~~(1) (h)~~, **(1) (I)**, the department may assess the hospital a  
17 penalty of 5% of the assessment for each month that the assessment  
18 and penalty are not paid up to a maximum of 50% of the assessment.  
19 The department may also refer for collection to the department of  
20 treasury past due amounts consistent with section 13 of 1941 PA  
21 122, MCL 205.13.

22 (f) The hospital quality assurance assessment fund is  
23 established in the state treasury. The department shall deposit the  
24 revenue raised through the quality assurance assessment with the  
25 state treasurer for deposit in the hospital quality assurance  
26 assessment fund.

27 (g) In each fiscal year governed by this subsection, the

1 **DEPARTMENT SHALL ONLY COLLECT AND EXPEND THE** quality assurance  
2 assessment ~~shall only be collected and expended~~ if Medicaid  
3 hospital inpatient DRG and outpatient reimbursement rates and  
4 disproportionate share hospital and graduate medical education  
5 payments are not below the level of rates and payments in effect on  
6 April 1, 2002 as a direct result of the quality assurance  
7 assessment collected under subsection ~~(1)(h)~~, **(1)(I)**, except as  
8 provided in subdivision (h).

9 (h) The **DEPARTMENT SHALL NOT ASSESS OR COLLECT THE** quality  
10 assurance assessment collected under subsection ~~(1)(h)~~ ~~shall not be~~  
11 ~~assessed or collected~~ **(1)(I)** after September 30, 2011 if the  
12 quality assurance assessment is not eligible for federal matching  
13 funds. Any portion of the quality assurance assessment collected  
14 from a hospital that is not eligible for federal matching funds  
15 ~~shall~~ **MUST** be returned to the hospital.

16 (i) The state retention amount of the quality assurance  
17 assessment collected under subsection ~~(1)(h)~~ ~~shall be~~ **(1)(I) IS**  
18 equal to 13.2% of the federal funds generated by the hospital  
19 quality assurance assessment, including the state retention amount.  
20 The 13.2% state retention amount described in this subdivision does  
21 not apply to the Healthy Michigan plan. In the fiscal year ending  
22 September 30, 2016, there is a 1-time additional retention amount  
23 of up to \$92,856,100.00. Beginning in the fiscal year ending  
24 September 30, 2017, and for each fiscal year thereafter, there is a  
25 retention amount of \$105,000,000.00 for each fiscal year for the  
26 Healthy Michigan plan. The state retention percentage ~~shall~~ **MUST** be  
27 applied proportionately to each hospital quality assurance

1 assessment program to determine the retention amount for each  
2 program. The state retention amount ~~shall~~**MUST** be appropriated each  
3 fiscal year to the department to support Medicaid expenditures for  
4 hospital services and therapy. These funds ~~shall~~**MUST** offset an  
5 identical amount of general fund/general purpose revenue originally  
6 appropriated for that purpose. By May 31, 2019, the department, the  
7 state budget office, and the Michigan Health and Hospital  
8 Association shall identify an appropriate retention amount for the  
9 fiscal year ending September 30, 2020 and each fiscal year  
10 thereafter.

11 (13) The department may establish a quality assurance  
12 assessment to increase ambulance reimbursement as follows:

13 (a) The quality assurance assessment authorized under this  
14 subsection ~~shall~~**MUST** be used to provide reimbursement to Medicaid  
15 ambulance providers. The department may promulgate rules to provide  
16 the structure of the quality assurance assessment authorized under  
17 this subsection and the level of the assessment.

18 (b) The department shall implement this subsection in a manner  
19 that complies with federal requirements necessary to ensure that  
20 the quality assurance assessment qualifies for federal matching  
21 funds.

22 (c) The total annual collections by the department under this  
23 subsection shall not exceed \$20,000,000.00.

24 (d) The **DEPARTMENT SHALL NOT COLLECT THE** quality assurance  
25 assessment authorized under this subsection ~~shall not be collected~~  
26 after October 1, 2019. The **DEPARTMENT SHALL NOT COLLECT OR ASSESS**  
27 **THE** quality assurance assessment authorized under this subsection

1 ~~shall no longer be collected or assessed~~ if the quality assurance  
 2 assessment authorized under this subsection is not eligible for  
 3 federal matching funds.

4 (14) The quality assurance assessment provided for under this  
 5 section is a tax that is levied on a health facility or agency.

6 (15) As used in this section:

7 (a) "Healthy Michigan plan" means the medical assistance ~~plan~~  
 8 **PROGRAM** described in section 105d of the social welfare act, 1939  
 9 PA 280, MCL 400.105d, that has a federal matching fund rate of not  
 10 less than 90%.

11 (b) "Medicaid" means that term as defined in section 22207.

#### 12 **PART 218. PAIN MANAGEMENT FACILITIES**

13 **SEC. 21801. (1) FOR PURPOSES OF THIS PART, THE WORDS AND**  
 14 **PHRASES DEFINED IN SECTIONS 21803 TO 21805 HAVE THE MEANINGS**  
 15 **ASCRIBED TO THEM IN THOSE SECTIONS.**

16 **(2) IN ADDITION, ARTICLE 1 CONTAINS GENERAL DEFINITIONS AND**  
 17 **PRINCIPLES OF CONSTRUCTION APPLICABLE TO ALL ARTICLES IN THIS CODE**  
 18 **AND PART 201 CONTAINS DEFINITIONS APPLICABLE TO THIS PART.**

19 **SEC. 21803. "CONTROLLED SUBSTANCE" MEANS THAT TERM AS DEFINED**  
 20 **IN SECTION 7104.**

21 **SEC. 21805. (1) "PAIN MANAGEMENT FACILITY" MEANS A FACILITY**  
 22 **WHERE A MAJORITY OF THE PATIENTS ARE PROVIDED TREATMENT FOR PAIN**  
 23 **THROUGH THE USE OF A CONTROLLED SUBSTANCE AND EITHER THE FACILITY'S**  
 24 **PRIMARY PRACTICE IS THE TREATMENT OF PAIN OR THE FACILITY**  
 25 **ADVERTISES FOR ANY TYPE OF PAIN MANAGEMENT SERVICE. PAIN MANAGEMENT**  
 26 **FACILITY DOES NOT INCLUDE ANY OF THE FOLLOWING:**

27 **(A) AN AMBULANCE OPERATION, AIRCRAFT TRANSPORT OPERATION,**

1 NONTRANSPORT PREHOSPITAL LIFE SUPPORT OPERATION, OR MEDICAL FIRST  
2 RESPONSE SERVICE.

3 (B) A COUNTY MEDICAL CARE FACILITY.

4 (C) A FREESTANDING SURGICAL OUTPATIENT FACILITY.

5 (D) A HOME FOR THE AGED.

6 (E) A HOSPITAL OR A FACILITY THAT IS OWNED AND OPERATED BY A  
7 HOSPITAL.

8 (F) A NURSING HOME.

9 (G) A HOSPICE.

10 (H) A HOSPICE RESIDENCE.

11 (I) A HOSPITAL LONG-TERM CARE UNIT.

12 (J) A HEALTH FACILITY OR AGENCY LISTED IN SUBDIVISIONS (A) TO  
13 (F) LOCATED IN A UNIVERSITY, COLLEGE, OR OTHER EDUCATIONAL  
14 INSTITUTION.

15 (K) AN EDUCATIONAL INSTITUTION TO THE EXTENT THAT IT PROVIDES  
16 INSTRUCTION TO INDIVIDUALS PREPARING TO PRACTICE AS A PHYSICIAN,  
17 PODIATRIST, DENTIST, NURSE, PHYSICIAN'S ASSISTANT, OPTOMETRIST, OR  
18 VETERINARIAN.

19 (2) "PAIN MANAGEMENT SERVICE" MEANS MEDICAL CARE SPECIALIZING  
20 IN MANAGING CHRONIC OR ACUTE PAIN.

21 (3) "PHYSICIAN" MEANS THAT TERM AS DEFINED IN SECTION 17001 OR  
22 17501.

23 (4) "PRACTICE OF MEDICINE" MEANS THAT TERM AS DEFINED IN  
24 SECTION 17001.

25 (5) "PRACTICE OF OSTEOPATHIC MEDICINE AND SURGERY" MEANS THAT  
26 TERM AS DEFINED IN SECTION 17501.

27 SEC. 21807. NOTWITHSTANDING SECTION 20141, BEGINNING JANUARY

1 1, 2018, A PERSON SHALL NOT ESTABLISH OR MAINTAIN AND OPERATE A  
2 PAIN MANAGEMENT FACILITY WITHOUT HAVING SUBMITTED A COMPLETED  
3 APPLICATION FOR LICENSURE AS A PAIN MANAGEMENT FACILITY. BEGINNING  
4 JUNE 1, 2018, A PERSON SHALL NOT ESTABLISH OR MAINTAIN AND OPERATE  
5 A PAIN MANAGEMENT FACILITY WITHOUT HAVING OBTAINED A LICENSE FROM  
6 THE DEPARTMENT.

7 SEC. 21809. (1) EXCEPT AS OTHERWISE PROVIDED IN THIS  
8 SUBSECTION, AN INDIVIDUAL WHO IS NOT A PHYSICIAN SHALL NOT HAVE AN  
9 OWNERSHIP INTEREST IN A PAIN MANAGEMENT FACILITY. THIS SUBSECTION  
10 DOES NOT APPLY TO A PAIN MANAGEMENT FACILITY ESTABLISHED AND  
11 OPERATING IN THIS STATE ON THE EFFECTIVE DATE OF THE AMENDATORY ACT  
12 THAT ADDED THIS PART UNLESS 1 OR MORE OF THE FOLLOWING HAVE  
13 OCCURRED:

14 (A) AN INDIVIDUAL EMPLOYED BY THE FACILITY HAS BEEN SANCTIONED  
15 BY A DISCIPLINARY SUBCOMMITTEE UNDER THIS CODE FOR AN ACT OR  
16 OMISSION INVOLVING A CONTROLLED SUBSTANCE OR HAS A CONVICTION  
17 INVOLVING A CONTROLLED SUBSTANCE.

18 (B) THE PAIN MANAGEMENT FACILITY HAS BEEN SANCTIONED UNDER  
19 THIS CODE FOR AN ACT OR OMISSION INVOLVING A CONTROLLED SUBSTANCE.

20 (2) IF 1 OF THE OWNERS OF A PAIN MANAGEMENT FACILITY THAT IS  
21 ESTABLISHED AND OPERATING IN THIS STATE ON THE EFFECTIVE DATE OF  
22 THE AMENDATORY ACT THAT ADDED THIS PART IS NOT A PHYSICIAN, THE  
23 OWNERS OF THE FACILITY SHALL DESIGNATE A PHYSICIAN WHO IS EMPLOYED  
24 BY THE PAIN MANAGEMENT FACILITY TO MEET THE REQUIREMENTS OF  
25 SUBSECTION (3).

26 (3) BEGINNING 1 YEAR AFTER THE EFFECTIVE DATE OF THE  
27 AMENDATORY ACT THAT ADDED THIS PART, THE OWNERS OF A PAIN



1 MANAGEMENT FACILITY SHALL ENSURE THAT A PHYSICIAN DESIGNATED UNDER  
2 SUBSECTION (2) OR AT LEAST 1 PHYSICIAN WHO HAS AN OWNERSHIP  
3 INTEREST IN THE PAIN MANAGEMENT FACILITY SHALL, FOR AT LEAST 50% OF  
4 THE TIME THAT A PATIENT IS PRESENT IN THE PAIN MANAGEMENT FACILITY,  
5 BE PHYSICALLY PRESENT IN THE FACILITY AND ENGAGING IN THE PRACTICE  
6 OF MEDICINE OR THE PRACTICE OF OSTEOPATHIC MEDICINE AND SURGERY.  
7 THE PHYSICIANS DESCRIBED IN THIS SUBSECTION MUST ALSO MEET 1 OF THE  
8 FOLLOWING:

9 (A) HOLD A SUBSPECIALTY CERTIFICATION IN PAIN MANAGEMENT  
10 ISSUED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES, A CERTIFICATE  
11 OF ADDED QUALIFICATION IN PAIN MANAGEMENT ISSUED BY THE AMERICAN  
12 OSTEOPATHIC ASSOCIATION BUREAU OF OSTEOPATHIC SPECIALISTS, OR AN  
13 EQUIVALENT CERTIFICATION OR CERTIFICATE AS DETERMINED BY THE  
14 DEPARTMENT.

15 (B) HOLD A SUBSPECIALTY CERTIFICATION IN HOSPICE AND  
16 PALLIATIVE MEDICINE ISSUED BY THE AMERICAN BOARD OF MEDICAL  
17 SPECIALTIES, A CERTIFICATE OF ADDED QUALIFICATION IN HOSPICE AND  
18 PALLIATIVE MEDICINE ISSUED BY THE AMERICAN OSTEOPATHIC ASSOCIATION  
19 BUREAU OF OSTEOPATHIC SPECIALISTS, OR AN EQUIVALENT CERTIFICATION  
20 OR CERTIFICATE AS DETERMINED BY THE DEPARTMENT.

21 (C) HOLD A BOARD CERTIFICATION ISSUED BY THE AMERICAN BOARD OF  
22 PAIN MANAGEMENT, THE AMERICAN BOARD OF INTERVENTIONAL PAIN  
23 PHYSICIANS, OR AN EQUIVALENT CERTIFICATION AS DETERMINED BY THE  
24 DEPARTMENT.

25 (D) HAVE COMPLETED A RESIDENCY OR FELLOWSHIP IN PAIN  
26 MANAGEMENT APPROVED BY THE DEPARTMENT OR MEET ANY OTHER EDUCATIONAL  
27 STANDARD AS DETERMINED BY THE DEPARTMENT.

1           SEC. 21811. (1) SUBJECT TO SUBSECTION (2), A PAIN MANAGEMENT  
2 FACILITY SHALL ACCEPT PRIVATE HEALTH INSURANCE AS A SOURCE OF  
3 PAYMENT FOR A GOOD OR SERVICE PROVIDED TO A PATIENT.

4           (2) A PAIN MANAGEMENT FACILITY SHALL ONLY ACCEPT PAYMENT FOR A  
5 GOOD OR SERVICE PROVIDED TO A PATIENT FROM THE PATIENT OR THE  
6 PATIENT'S INSURER, GUARANTOR, SPOUSE, PARENT, LEGAL GUARDIAN, OR  
7 LEGAL CUSTODIAN.

8           Enacting section 1. This amendatory act takes effect 90 days  
9 after the date it is enacted into law.