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:

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

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

(b) A county medical care facility.

(c) A freestanding surgical outpatient facility.

(d) A health maintenance organization.

(e) A home for the aged.

(f) A hospital.

(g) A nursing home.

(h) A hospice.

(i) A hospice residence.

(j) A facility or agency listed in subdivisions (a) to (g) located in a university, college, or other educational institution.

(K) A PAIN MANAGEMENT FACILITY.

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

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

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

condition with a terminal prognosis.

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

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

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

(a) A unit in a state correctional facility.

(b) A hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Whether a facility at which surgical abortions were

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

(6) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Freestanding surgical outpatient facilities	$500.00 per facility license.
(b) Hospitals	$500.00 per facility license and $10.00 per licensed bed.

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

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

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

(f) Hospice residences.....$500.00 per facility license and $5.00 per licensed bed.

(G) PAIN MANAGEMENT FACILITIES..$1,000.00 PER FACILITY LICENSE.

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

(I) ~~(h)~~ Subject to subsection (12), quality assurance assessment for hospitals.....at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching

		requirements, after consideration for the amounts in subsection (12)(a) and (i).
(J) ~~(i)~~ Initial licensure application fee for subdivisions (a), (b), (c), (e), ~~and~~ (f), **AND (G)**	.....	$2,000.00 per initial license.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

purposes and under the following specific circumstances:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) As used in this section:

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

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

PART 218. PAIN MANAGEMENT FACILITIES

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

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

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

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

(A) AN AMBULANCE OPERATION, AIRCRAFT TRANSPORT OPERATION,

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

(B) A COUNTY MEDICAL CARE FACILITY.

(C) A FREESTANDING SURGICAL OUTPATIENT FACILITY.

(D) A HOME FOR THE AGED.

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

(F) A NURSING HOME.

(G) A HOSPICE.

(H) A HOSPICE RESIDENCE.

(I) A HOSPITAL LONG-TERM CARE UNIT.

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

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

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

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

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

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

SEC. 21807. NOTWITHSTANDING SECTION 20141, BEGINNING JANUARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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