Act No. 234
Public Acts of 2003
Approved by the Governor
December 23, 2003
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STATE OF MICHIGAN
92ND LEGISLATURE
REGULAR SESSION OF 2003

Introduced by Reps. Newell, Vander Veen, Stakoe, Kooiman, Paletko, Caswell, Ehardt, Emmons, Sak, Shaffer, Rivet, Farhat, Nofs, Taub, Hummel, Palsrok, Sheen, Hart, Stahl, Ward, Robertson, Hune, Rocca, Pappageorge, Lipsey, Howell, Adamini, Woronchak, Gillard, O'Neil and Clack

ENROLLED HOUSE BILL No. 4655

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," by amending the title and sections 16186, 16221, 16226, and 20161 (MCL 333.16186, 333.16221, 333.16226, and 333.20161), the title as amended by 2002 PA 303, sections 16186 and 16226 as amended by 2002 PA 643, section 16221 as amended by 2002 PA 402, and section 20161 as amended by 2003 PA 113, and by adding section 16193.

The People of the State of Michigan enact:

TITLE

An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to

provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates.

Sec. 16186. (1) An individual who is licensed to practice a health profession in another state or, until January 1, 2007, is licensed to practice a health profession in a province of Canada, who is registered in another state, or who holds a health profession specialty field license or specialty certification from another state and who applies for licensure, registration, specialty certification, or a health profession specialty field license in this state may be granted an appropriate license or registration or specialty certification or health profession specialty field license upon satisfying the board or task force to which the applicant applies as to all of the following:

(a) The applicant substantially meets the requirements of this article and rules promulgated under this article for licensure, registration, specialty certification, or a health profession specialty field license.

(b) Subject to subsection (3), the applicant is licensed, registered, specialty certified, or specialty licensed in another state or, until January 1, 2007, is licensed in a province in Canada that maintains standards substantially equivalent to those of this state.

(c) Subject to subsection (3), until January 1, 2007, if the applicant is licensed to practice a health profession in a province in Canada, the applicant completed the educational requirements in Canada or in the United States for licensure in Canada or in the United States.

(d) Until January 1, 2007, if the applicant is licensed to practice a health profession in a province in Canada, that the applicant will perform the professional services for which he or she bills in this state, and that any resulting request for third party reimbursement will originate from the applicant's place of employment in this state.

(2) Before granting a license, registration, specialty certification, or a health profession specialty field license to the applicant, the board or task force to which the applicant applies may require the applicant to appear personally before it for an interview to evaluate the applicant's relevant qualifications.

(3) For purposes of the 2002 amendatory act that added this subsection, an applicant who is licensed in a province in Canada who meets the requirements of subsection (1)(c) and takes and passes a national examination in this country that is approved by the appropriate Michigan licensing board, or who takes and passes a Canadian national examination approved by the appropriate Michigan licensing board, is considered to have met the requirements of subsection (1)(b). This subsection does not apply if the department, in consultation with the appropriate licensing board, promulgates a rule disallowing the use of this subsection for an applicant licensed in a province in Canada.

Sec. 16193. Acceptance of a license or registration under this article constitutes implied consent to submit to a chemical analysis under section 430 of the Michigan penal code, 1931 PA 328, MCL 750.430.

Sec. 16221. The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:

(a) A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully practice the health profession.

(b) Personal disqualifications, consisting of 1 or more of the following:

(*i*) Incompetence.

(*ii*) Subject to sections 16165 to 16170a, substance abuse as defined in section 6107.

(*iii*) Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

(*iv*) Declaration of mental incompetence by a court of competent jurisdiction.

(*v*) Conviction of a misdemeanor punishable by imprisonment for a maximum term of 2 years; a misdemeanor involving the illegal delivery, possession, or use of a controlled substance; or a felony. A certified copy of the court record is conclusive evidence of the conviction.

(*vi*) Lack of good moral character.

(*vii*) Conviction of a criminal offense under sections 520b to 520g of the Michigan penal code, 1931 PA 328, MCL 750.520b to 750.520g. A certified copy of the court record is conclusive evidence of the conviction.

(*viii*) Conviction of a violation of section 492a of the Michigan penal code, 1931 PA 328, MCL 750.492a. A certified copy of the court record is conclusive evidence of the conviction.

(*ix*) Conviction of a misdemeanor or felony involving fraud in obtaining or attempting to obtain fees related to the practice of a health profession. A certified copy of the court record is conclusive evidence of the conviction.

(*x*) Final adverse administrative action by a licensure, registration, disciplinary, or certification board involving the holder of, or an applicant for, a license or registration regulated by another state or a territory of the United States, by the United States military, by the federal government, or by another country. A certified copy of the record of the board is conclusive evidence of the final action.

(*xi*) Conviction of a misdemeanor that is reasonably related to or that adversely affects the licensee's ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence of the conviction.

(*xii*) Conviction of a violation of section 430 of the Michigan penal code, 1931 PA 328, MCL 750.430. A certified copy of the court record is conclusive evidence of the conviction.

(c) Prohibited acts, consisting of 1 or more of the following:

(*i*) Fraud or deceit in obtaining or renewing a license or registration.

(*ii*) Permitting the license or registration to be used by an unauthorized person.

(*iii*) Practice outside the scope of a license.

(*iv*) Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 or a drug as defined in section 7105 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.

(d) Unethical business practices, consisting of 1 or more of the following:

(*i*) False or misleading advertising.

(*ii*) Dividing fees for referral of patients or accepting kickbacks on medical or surgical services, appliances, or medications purchased by or in behalf of patients.

(*iii*) Fraud or deceit in obtaining or attempting to obtain third party reimbursement.

(e) Unprofessional conduct, consisting of 1 or more of the following:

(*i*) Misrepresentation to a consumer or patient or in obtaining or attempting to obtain third party reimbursement in the course of professional practice.

(*ii*) Betrayal of a professional confidence.

(*iii*) Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service.

(*iv*) Either of the following:

(A) A requirement by a licensee other than a physician that an individual purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest.

(B) A referral by a physician for a designated health service that violates section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, or a regulation promulgated under that section. Section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, and the regulations promulgated under that section, as they exist on June 3, 2002, are incorporated by reference for purposes of this subparagraph. A disciplinary subcommittee shall apply section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, and the regulations promulgated under that section regardless of the source of payment for the designated health service referred and rendered. If section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, or a regulation promulgated under that section is revised after June 3, 2002, the department shall officially take notice of the revision. Within 30 days after taking notice of the revision, the department shall decide whether or not the revision pertains to referral by physicians for designated health services and continues to protect the public from inappropriate referrals by physicians. If the department decides that the revision does both of those things, the department may promulgate rules to incorporate the revision by reference. If the department does promulgate rules to incorporate the revision by reference, the department shall not make any changes to the revision. As used in this subparagraph, "designated health service" means that term as defined in section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, and the regulations promulgated under that section and "physician" means that term as defined in sections 17001 and 17501.

(*v*) For a physician who makes referrals pursuant to section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, or a regulation promulgated under that section, refusing to accept a reasonable proportion of patients eligible for medicaid and refusing to accept payment from medicaid or medicare as payment in full for a treatment, procedure, or service for which the physician refers the individual and in which the physician has a financial interest. A physician who owns all or part of a facility in which he or she provides surgical services is not subject to this subparagraph if a referred surgical procedure he or she performs in the facility is not reimbursed at a minimum of the appropriate medicaid or medicare outpatient fee schedule, including the combined technical and professional components.

(f) Beginning June 3, 2003, the department of consumer and industry services shall prepare the first of 3 annual reports on the effect of this amendatory act on access to care for the uninsured and medicaid patients. The department shall report on the number of referrals by licensees of uninsured and medicaid patients to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest.

(g) Failure to report a change of name or mailing address within 30 days after the change occurs.

(h) A violation, or aiding or abetting in a violation, of this article or of a rule promulgated under this article.

(i) Failure to comply with a subpoena issued pursuant to this part, failure to respond to a complaint issued under this article or article 7, failure to appear at a compliance conference or an administrative hearing, or failure to report under section 16222 or 16223.

(j) Failure to pay an installment of an assessment levied pursuant to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, within 60 days after notice by the appropriate board.

(k) A violation of section 17013 or 17513.

(*l*) Failure to meet 1 or more of the requirements for licensure or registration under section 16174.

(m) A violation of section 17015 or 17515.

(n) A violation of section 17016 or 17516.

(o) Failure to comply with section 9206(3).

(p) A violation of section 5654 or 5655.

(q) A violation of section 16274.

(r) A violation of section 17020 or 17520.

Sec. 16226. (1) After finding the existence of 1 or more of the grounds for disciplinary subcommittee action listed in section 16221, a disciplinary subcommittee shall impose 1 or more of the following sanctions for each violation:

Violations of Section 16221	Sanctions
Subdivision (a), (b)(*ii*), (b)(*iv*), (b)(*vi*), or (b)(*vii*)	Probation, limitation, denial, suspension, revocation, restitution, community service, or fine.
Subdivision (b)(*viii*)	Revocation or denial.
Subdivision (b)(*i*), (b)(*iii*), (b)(*v*), (b)(*ix*), (b)(*x*), (b)(*xi*), or (b)(*xii*)	Limitation, suspension, revocation, denial, probation, restitution, community service, or fine.
Subdivision (c)(*i*)	Denial, revocation, suspension, probation, limitation, community service, or fine.
Subdivision (c)(*ii*)	Denial, suspension, revocation, restitution, community service, or fine.
Subdivision (c)(*iii*)	Probation, denial, suspension, revocation, restitution, community service, or fine.
Subdivision (c)(*iv*) or (d)(*iii*)	Fine, probation, denial, suspension, revocation, community service, or restitution.
Subdivision (d)(*i*) or (d)(*ii*)	Reprimand, fine, probation, community service, denial, or restitution.
Subdivision (e)(*i*)	Reprimand, fine, probation, limitation, suspension, community service, denial, or restitution.
Subdivision (e)(*ii*) or (i)	Reprimand, probation, suspension, restitution, community service, denial, or fine.
Subdivision (e)(*iii*), (e)(*iv*), or (e)(*v*)	Reprimand, fine, probation, suspension, revocation, limitation, community service, denial, or restitution.
Subdivision (g)	Reprimand or fine.
Subdivision (h)	Reprimand, probation, denial, suspension, revocation, limitation, restitution, community service, or fine.
Subdivision (j)	Suspension or fine.
Subdivision (k), (p), or (r)	Reprimand or fine.
Subdivision (*l*)	Reprimand, denial, or limitation.
Subdivision (m) or (o)	Denial, revocation, restitution, probation, suspension, limitation, reprimand, or fine.
Subdivision (n)	Revocation or denial.
Subdivision (q)	Revocation.

(2) Determination of sanctions for violations under this section shall be made by a disciplinary subcommittee. If, during judicial review, the court of appeals determines that a final decision or order of a disciplinary subcommittee prejudices substantial rights of the petitioner for 1 or more of the grounds listed in section 106 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.306, and holds that the final decision or order is unlawful and is to be set aside, the court shall state on the record the reasons for the holding and may remand the case to the disciplinary subcommittee for further consideration.

(3) A disciplinary subcommittee may impose a fine of up to, but not exceeding, $250,000.00 for a violation of section 16221(a) or (b).

(4) A disciplinary subcommittee may require a licensee or registrant or an applicant for licensure or registration who has violated this article or article 7 or a rule promulgated under this article or article 7 to satisfactorily complete an educational program, a training program, or a treatment program, a mental, physical, or professional competence examination, or a combination of those programs and examinations.

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. Except as otherwise provided in this article, fees and assessments shall be paid in accordance with the following schedule:

(a) Freestanding surgical outpatient facilities	$238.00 per facility.
(b) Hospitals	$8.28 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units	$2.20 per licensed bed.
(d) Homes for the aged	$6.27 per licensed bed.
(e) Clinical laboratories	$475.00 per laboratory.
(f) Hospice residences	$200.00 per license survey; and $20.00 per licensed bed.
(g) Subject to subsection (13), quality assurance assessment for nongovernmentally owned nursing homes and hospital long-term care units	an amount resulting in not more than 6% of total industry revenues.
(h) Subject to subsection (14), 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 (14)(a) and (k).

(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) The base fee for a certificate of need is $750.00 for each application. For a project requiring a projected capital expenditure of more than $150,000.00 but less than $1,500,000.00, an additional fee of $2,000.00 shall be added to the base fee. For a project requiring a projected capital expenditure of $1,500,000.00 or more, an additional fee of $3,500.00 shall be added to the base fee.

(4) If licensure is for more than 1 year, the fees described in subsection (1) are multiplied by the number of years for which the license is issued, and the total amount of the fees shall be collected in the year in which the license is issued.

(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 department may charge a fee to recover the cost of purchase or production and distribution of proficiency evaluation samples that are supplied to clinical laboratories pursuant to section 20521(3).

(8) In addition to the fees imposed under subsection (1), a clinical laboratory shall submit a fee of $25.00 to the department for each reissuance during the licensure period of the clinical laboratory's license.

(9) Except for the licensure of clinical laboratories, not more than half the annual cost of licensure activities as determined by the department shall be provided by license fees.

(10) 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 calculated in accordance with the state standardized travel regulations of the department of management and budget in effect at the time of the travel.

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

(12) Except as otherwise provided in this section, the fees and assessments collected under this section shall be deposited in the state treasury, to the credit of the general fund.

(13) The quality assurance assessment collected under subsection (1)(g) and all federal matching funds attributed to that assessment shall 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 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.

(b) The quality assurance assessment shall be implemented on May 10, 2002.

(c) The quality assurance assessment is based on the number of licensed nursing home beds and the number of licensed hospital long-term care unit beds in existence on July 1 of each year, shall be assessed upon implementation pursuant to subdivision (b) and subsequently on October 1 of each following year, and is payable on a quarterly basis, the first payment due 90 days after the date the assessment is assessed.

(d) Beginning October 1, 2007, the department shall no longer assess or collect the quality assurance assessment or apply for federal matching funds.

(e) Upon implementation pursuant to subdivision (b), the department of community health 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 of community health shall maintain the medicaid nursing home reimbursement payment increase financed by the quality assurance assessment.

(f) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment qualifies for federal matching funds.

(g) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection (1)(g), the department of community health 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 of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(h) The medicaid nursing home quality assurance assessment fund is established in the state treasury. The department of community health 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.

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

(j) The quality assurance assessment collected under subsection (1)(g) shall be prorated 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.

(k) In each fiscal year governed by this subsection, medicaid reimbursement rates shall 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).

(*l*) The amounts listed in this subdivision are appropriated for the department of community health, subject to the conditions set forth in this subsection, for the fiscal year ending September 30, 2003:

MEDICAL SERVICES		
Long-term care services	$	1,469,003,900
Gross appropriation	$	1,469,003,900
Appropriated from:		
Federal revenues:		
Total federal revenues		814,122,200
Special revenue funds:		
Medicaid quality assurance assessment		44,829,000
Total local revenues		8,445,100
State general fund/general purpose	$	601,607,600

(m) In fiscal year 2003-2004, $18,900,000.00 of the quality assurance assessment collected pursuant to subsection (1)(g) shall be appropriated to the department of community health to support medicaid expenditures for long-term care services. These funds shall offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

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

(a) Part of the quality assurance assessment shall be used to maintain the increased medicaid reimbursement rate increases as provided for in subdivision (d). A portion of the funds collected from the quality assurance assessment may be used to offset any reduction to existing intergovernmental transfer programs with public hospitals that may result from implementation of the enhanced medicaid payments financed by the quality assurance assessment. Any portion of the funds collected from the quality assurance assessment reduced because of existing intergovernmental transfer programs shall be used to finance medicaid hospital appropriations.

(b) The quality assurance assessment shall be implemented on October 1, 2002.

(c) The quality assurance assessment shall 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, 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.

(d) Upon implementation pursuant to subdivision (b), the department of community health 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 of community health shall maintain the hospital medicaid reimbursement rate increase financed by the quality assurance assessments.

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

(f) If a hospital fails to pay the assessment required by subsection (1)(h), the department of community health 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 of community health 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 hospital quality assurance assessment fund is established in the state treasury. The department of community health shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the hospital quality assurance assessment fund.

(h) In each fiscal year governed by this subsection, 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), except as provided in subdivision (j).

(i) The amounts listed in this subdivision are appropriated for the department of community health, subject to the conditions set forth in this subsection, for the fiscal year ending September 30, 2003:

MEDICAL SERVICES		
Hospital services and therapy	$	149,200,000
Gross appropriation	$	149,200,000
Appropriated from:		
Federal revenues:		
Total federal revenues		82,686,800
Special revenue funds:		
Medicaid quality assurance assessment		66,513,500
Total local revenues		0
State general fund/general purpose	$	0

(j) The quality assurance assessment collected under subsection (1)(h) shall no longer be assessed or collected after September 30, 2004, or in the event that 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 be returned to the hospital.

(k) In fiscal year 2002-2003, $18,900,000.00 of the quality assurance assessment shall be deposited into the general fund.

(*l*) In fiscal year 2003-2004, $18,900,000.00 of the quality assurance assessment collected pursuant to subsection (1)(h) shall be appropriated to the department of community health to support medicaid expenditures for hospital services and therapy. These funds shall offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

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

(16) As used in this section, "medicaid" means that term as defined in section 22207.

Enacting section 1. This amendatory act does not take effect unless House Bill No. 4656 of the 92nd Legislature is enacted into law.

Enacting section 2. (1) Section 20161 as amended by this amendatory act is curative and intended to express the original intent of the legislature regarding the application of 2002 PA 303 and 2002 PA 562, as amended by 2003 PA 113.

(2) Section 20161 as amended by this amendatory act is retroactive and is effective for all quality assurance assessments made after May 9, 2002.

This act is ordered to take immediate effect.

Clerk of the House of Representatives

Secretary of the Senate

Approved

Governor