HOUSE BILL NO. 5510

February 20, 2020, Introduced by Reps. Reilly, Steven Johnson, Eisen, Markkanen, LaFave and Maddock and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 2612, 20101, 20115, 20145, 20155, 20161, 20164, 20165, 20166, 21551, 21562, and 21563 (MCL 333.2612, 333.20101, 333.20115, 333.20145, 333.20155, 333.20161, 333.20164, 333.20165, 333.20166, 333.21551, 333.21562, and 333.21563), section 2612 as added by 1990 PA 138, sections 20101 and 20166 as amended by 1988 PA 332, section 20115 as amended by 2012 PA 499, section 20145 as amended by 2015 PA 104, section 20155 as amended by 2015 PA 155, section 20161 as amended by 2019 PA 74, section 20164 as

amended by 1990 PA 179, section 20165 as amended by 2008 PA 39, section 21551 as amended by 1990 PA 331, and sections 21562 and 21563 as added by 1990 PA 252; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2612. (1) The department may establish with Michigan ~~state university~~ **State University** and other ~~parties~~ **persons** determined appropriate by the department a nonprofit corporation ~~pursuant to~~ **under** the nonprofit corporation act, ~~Act No. 162 of the Public Acts of 1982, being sections~~ **1982 PA 162, MCL** 450.2101 to 450.3192. ~~of the Michigan Compiled Laws.~~ The purpose of the corporation ~~shall be~~ **is** to establish and operate a center for rural health. In fulfilling its purpose, the corporation shall do all of the following:

(a) Develop a coordinated rural health program that addresses critical questions and problems related to rural health and provides mechanisms for influencing health care policy.

(b) Perform and coordinate research regarding rural health issues.

(c) Periodically review state and federal laws and judicial decisions pertaining to health care policy and analyze the impact on the delivery of rural health care.

(d) Provide technical assistance and act as a resource for the rural health community in this state.

(e) Suggest changes in medical education curriculum that would ~~be beneficial to~~ **benefit** rural health.

(f) Assist rural communities with all of the following:

(*i*) Applications for grants.

(*ii*) The recruitment and retention of health professionals.

(*iii*) Needs assessments and planning activities for rural health facilities.

(g) Serve as an advocate for rural health concerns.

(h) Conduct periodic seminars on rural health issues.

(i) Establish and implement a visiting professor program.

(j) Conduct ~~consumer oriented~~ **consumer-oriented** rural health education programs.

~~(k) Designate a certificate of need ombudsman to provide technical assistance and consultation to rural health care providers and rural communities regarding certificate of need proposals and applications under part 222. The ombudsman shall also act as an advocate for rural health concerns in the development of certificate of need review standards under part 222.~~

(2) The incorporators of the corporation shall select a board of directors consisting of a representative from each of the following organizations:

(a) The Michigan ~~state medical society~~ **State Medical Society** or its successor. The representative ~~appointed~~ **selected** under this subdivision ~~shall~~ **must** be a physician practicing in a county with a population of not more than 100,000.

(b) The Michigan ~~osteopathic physicians' society~~ **Osteopathic Association** or its successor. The representative ~~appointed~~ **selected** under this subdivision ~~shall~~ **must** be a physician practicing in a county with a population of not more than 100,000.

(c) The Michigan ~~nurses association~~ **Nurses Association** or its successor. The representative ~~appointed~~ **selected** under this subdivision ~~shall~~ **must** be a nurse practicing in a county with a population of not more than 100,000.

(d) The Michigan ~~hospital association~~ **Health and Hospital**

Association or its successor. The representative selected under this subdivision ~~shall~~ **must** be from a hospital in a county with a population of not more than 100,000.

(e) The Michigan ~~primary care association~~ **Primary Care Association** or its successor. The representative ~~appointed~~ **selected** under this subdivision ~~shall~~ **must** be a health professional practicing in a county with a population of not more than 100,000.

(f) The Michigan ~~association~~ **Association** for ~~local public health~~ **Local Public Health** or its successor. The representative ~~appointed~~ **selected under this subdivision must be** from a county health department for a county with a population of not more than 100,000 or from a district health department with at least 1 member county with a population of not more than 100,000.

(g) The office of the governor.

(h) The department. ~~of public health.~~

(i) The department of ~~commerce~~ **licensing and regulatory affairs**.

(j) The Michigan senate. The individual selected under this subdivision ~~shall~~ **must** be from a district located at least in part in a county with a population of not more than 100,000.

(k) The Michigan house of representatives. The individual selected under this subdivision ~~shall~~ **must** be from a district located at least in part in a county with a population of not more than 100,000.

(3) The board of directors of the corporation shall appoint an internal management committee for the center for rural health. The management committee ~~shall~~ **must** consist of representatives from each of the following:

(a) The ~~college~~ **College** of ~~human medicine~~ **Human Medicine** of

Michigan ~~state university.~~**State University.**

(b) The ~~college~~ **College** of ~~osteopathic medicine~~ **Osteopathic Medicine** of Michigan ~~state university.~~**State University.**

(c) The ~~college~~ **College** of ~~nursing~~ **Nursing** of Michigan ~~state university.~~**State University.**

(d) The ~~college~~ **College** of ~~veterinary medicine~~ **Veterinary Medicine** of Michigan ~~state university.~~**State University.**

(e) The ~~cooperative extension service of~~ Michigan ~~state university.~~**State University Extension.**

(f) The department. ~~of public health.~~

Sec. 20101. (1) The words and phrases defined in sections 20102 to 20109 apply to all parts in this article ~~except part 222~~ and 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.

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) 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. 20145. (1) Before contracting for and initiating a construction project involving new construction, additions, modernizations, or conversions of a health facility or agency with a capital expenditure of $1,000,000.00 or more, a person shall obtain a construction permit from the department. ~~The department shall not issue the permit under this subsection unless the applicant holds a valid certificate of need if a certificate of need is required for the project under part 222.~~

(2) To protect the public health, safety, and welfare, the department may promulgate rules to require construction permits for projects other than those described in subsection (1) and the submission of plans for other construction projects to expand or change service areas and services provided.

~~(3) If a construction project requires a construction permit under subsection (1) or (2), but does not require a certificate of need under part 222, the department shall require the applicant to submit information considered necessary by the department to assure that the capital expenditure for the project is not a covered capital expenditure as defined in section 22203(9).~~

(3) ~~(4) If~~ **For** a construction project **that** requires a construction permit under subsection (1), ~~but does not require a certificate of need under part 222,~~ the department shall require the applicant to submit information on a 1-page sheet, along with the application for a construction permit, consisting of all of the following:

(a) A short description of the reason for the project and the funding source.

(b) A contact person for further information, including **the person's** address and phone number.

(c) The estimated resulting increase or decrease in annual operating costs.

(d) The current governing board membership of the applicant.

(e) The entity, if any, that owns the applicant.

(4) ~~(5)~~ The **department shall make the** information filed under subsection ~~(4) shall be made~~ **(3)** publicly available ~~by the department~~ by the same methods used to make information about certificate of need applications **under former part 222** publicly available.

(5) ~~(6)~~ The review and approval of architectural plans and narrative ~~shall~~ **must** require that the proposed construction project is designed and constructed in accord with applicable statutory and other regulatory requirements. In performing a construction permit review for a health facility or agency under this section, the department shall, at a minimum, apply the standards contained in the document entitled "**The 2007** Minimum Design Standards for Health Care Facilities in Michigan" published by the department. ~~and dated July 2007.~~ The standards are incorporated by reference for purposes of this subsection. The department may promulgate rules that are more stringent than the standards if necessary to protect the public health, safety, and welfare.

(6) ~~(7)~~ The department shall promulgate rules to further prescribe the scope of construction projects and other alterations subject to review under this section.

(7) ~~(8)~~ The department may waive the applicability of this section to a construction project or alteration if the waiver will not affect the public health, safety, and welfare.

(8) ~~(9)~~ Upon request by the person initiating a construction project, the department may review and issue a construction permit

to a construction project that is not subject to subsection (1) or (2) if the department determines that the review will promote the public health, safety, and welfare.

(9) ~~(10)~~ The department shall assess a fee for each review conducted under this section. The fee is ~~.5%~~ **0.5%** of the first $1,000,000.00 of capital expenditure and ~~.85%~~ **0.85%** of any amount over $1,000,000.00 of capital expenditure, up to a maximum of $60,000.00.

(10) ~~(11)~~ As used in this section, "capital expenditure" means ~~that term as defined in section 22203(2), except that capital expenditure does not include the cost of equipment that is not fixed equipment.~~**an expenditure for a single project, including cost of construction, engineering, and fixed equipment that under generally accepted accounting principles is not properly chargeable as an expense of operation. Capital expenditure includes a lease or comparable arrangement by or on behalf of a health facility to obtain a health facility, licensed part of a health facility, or fixed equipment for a health facility, if the actual purchase of a health facility, licensed part of a health facility, or fixed equipment for a health facility would have been considered a capital expenditure under former part 222. Capital expenditure includes the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of physical plant and fixed equipment.**

Sec. 20155. (1) Except as otherwise provided in this section and section 20155a, the department shall make at least 1 visit to each licensed health facility or agency every 3 years for survey

and evaluation for the purpose of licensure. A visit made according to a complaint ~~shall~~ **must** be unannounced. Except for a county medical care facility, a home for the aged, a nursing home, or a hospice residence, the department shall determine whether the visits that are not made according to a complaint are announced or unannounced. The department shall ensure that each newly hired nursing home surveyor, as part of his or her basic training, is assigned full-time to a licensed nursing home for at least 10 days within a 14-day period to observe actual operations outside of the survey process before the trainee begins oversight responsibilities.

(2) The department shall establish a process that ensures both of the following:

(a) A newly hired nursing home surveyor does not make independent compliance decisions during his or her training period.

(b) A nursing home surveyor is not assigned as a member of a survey team for a nursing home in which he or she received training for 1 standard survey following the training received in that nursing home.

(3) The department shall perform a criminal history check on all nursing home surveyors in the manner provided for in section 20173a.

(4) A member of a survey team must not be employed by a licensed nursing home or a nursing home management company doing business in this state at the time of conducting a survey under this section. The department shall not assign an individual to be a member of a survey team for purposes of a survey, evaluation, or consultation visit at a nursing home in which he or she was an employee within the preceding 3 years.

(5) The department shall invite representatives from all nursing home provider organizations and the state long-term care ombudsman or his or her designee to participate in the planning process for the joint provider and surveyor training sessions. The department shall include at least 1 representative from nursing home provider organizations that do not own or operate a nursing home representing 30 or more nursing homes statewide in internal surveyor group quality assurance training provided for the purpose of general clarification and interpretation of existing or new regulatory requirements and expectations.

(6) The department shall make available online the general civil service position description related to the required qualifications for individual surveyors. The department shall use the required qualifications to hire, educate, develop, and evaluate surveyors.

(7) The department shall ensure that each annual survey team is composed of an interdisciplinary group of professionals, 1 of whom must be a registered nurse. Other members may include social workers, therapists, dietitians, pharmacists, administrators, physicians, sanitarians, and others who may have the expertise necessary to evaluate specific aspects of nursing home operation.

(8) The department shall semiannually provide for joint training with nursing home surveyors and providers on at least 1 of the 10 most frequently issued federal citations in this state during the past calendar year. The department shall develop a protocol for the review of citation patterns compared to regional outcomes and standards and complaints regarding the nursing home survey process. The department shall include the review under this subsection in the report required under subsection (20). Except as

otherwise provided in this subsection, each member of a department nursing home survey team who is a health professional licensee under article 15 shall earn not less than 50% of his or her required continuing education credits, if any, in geriatric care. If a member of a nursing home survey team is a pharmacist licensed under article 15, he or she shall earn not less than 30% of his or her required continuing education credits in geriatric care.

(9) Subject to subsection (12), the department may waive the visit required by subsection (1) if a health facility or agency, requests a waiver and submits the following as applicable and if all of the requirements of subsection (11) are met:

(a) Evidence that it is currently fully accredited by a body with expertise in the health facility or agency type and the accrediting organization is accepted by the United States Department of Health and Human Services for purposes of ~~section 1865 of the social security act,~~ 42 USC 1395bb.

(b) A copy of the most recent accreditation report, or executive summary, issued by a body described in subdivision (a), and the health facility's or agency's responses to the accreditation report is submitted to the department at least 30 days from license renewal. Submission of an executive summary does not prevent or prohibit the department from requesting the entire accreditation report if the department considers it necessary.

(c) For a nursing home, a standard federal certification survey conducted within the immediately preceding 9 to 15 months that shows substantial compliance or has an accepted plan of correction, if applicable.

(10) Except as otherwise provided in subsection (14), accreditation information provided to the department under

subsection (9) is confidential, is not a public record, and is not subject to court subpoena. The department shall use the accreditation information only as provided in this section and properly destroy the documentation after a decision on the waiver request is made.

(11) The department shall grant a waiver under subsection (9) if the accreditation report submitted under subsection (9)(b) is less than 3 years old or the standard federal survey submitted under subsection (9)(c) is less than 15 months old and there is no indication of substantial noncompliance with licensure standards or of deficiencies that represent a threat to public safety or patient care. If the accreditation report or standard federal survey is too old, the department may deny the waiver request and conduct the visits required under subsection (9). Denial of a waiver request by the department is not subject to appeal.

(12) This section does not prohibit the department from citing a violation of this part during a survey, conducting investigations or inspections according to section 20156, or conducting surveys of health facilities or agencies for the purpose of complaint investigations or federal certification. This section does not prohibit the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, from conducting annual surveys of hospitals, nursing homes, and county medical care facilities.

(13) At the request of a health facility or agency, the department may conduct a consultation engineering survey of a health facility and provide professional advice and consultation regarding health facility construction and design. A health facility or agency may request a voluntary consultation survey

under this subsection at any time between licensure surveys. The fees for a consultation engineering survey are the same as the fees established for waivers under section ~~20161(8).~~**20161(7).**

(14) If the department determines that substantial noncompliance with licensure standards exists or that deficiencies that represent a threat to public safety or patient care exist based on a review of an accreditation report submitted under subsection (9)(b), the department shall prepare a written summary of the substantial noncompliance or deficiencies and the health facility's or agency's response to the department's determination. The department's written summary and the health facility's or agency's response are public documents.

(15) The department or a local health department shall conduct investigations or inspections, other than inspections of financial records, of a county medical care facility, home for the aged, nursing home, or hospice residence without prior notice to the health facility or agency. An employee of a state agency charged with investigating or inspecting the health facility or agency or an employee of a local health department who directly or indirectly gives prior notice regarding an investigation or an inspection, other than an inspection of the financial records, to the health facility or agency or to an employee of the health facility or agency, is guilty of a misdemeanor. Consultation visits that are not for the purpose of annual or follow-up inspection or survey may be announced.

(16) The department shall maintain a record indicating whether a visit and inspection is announced or unannounced. Survey findings gathered at each health facility or agency during each visit and inspection, whether announced or unannounced, ~~shall~~ **must** be taken

into account in licensure decisions.

(17) The department shall require periodic reports and a health facility or agency shall give the department access to books, records, and other documents maintained by a health facility or agency to the extent necessary to carry out the purpose of this article and the rules promulgated under this article. The department shall not divulge or disclose the contents of the patient's clinical records in a manner that identifies an individual except under court order. The department may copy health facility or agency records as required to document findings. Surveyors shall use electronic resident information, whenever available, as a source of survey-related data and shall request facility assistance to access the system to maximize data export.

(18) The department may delegate survey, evaluation, or consultation functions to another state agency or to a local health department qualified to perform those functions. The department shall not delegate survey, evaluation, or consultation functions to a local health department that owns or operates a hospice or hospice residence licensed under this article. The department shall delegate under this subsection by cost reimbursement contract between the department and the state agency or local health department. The department shall not delegate survey, evaluation, or consultation functions to nongovernmental agencies, except as provided in this section. The voluntary inspection described in this subsection must be agreed upon by both the licensee and the department.

(19) If, upon investigation, the department or a state agency determines that an individual licensed to practice a profession in this state has violated the applicable licensure statute or the

rules promulgated under that statute, the department, state agency, or local health department shall forward the evidence it has to the appropriate licensing agency.

(20) The department may consolidate all information provided for any report required under this section and section 20155a into a single report. The department shall report to the appropriations subcommittees, the senate and house of representatives standing committees having jurisdiction over issues involving senior citizens, and the fiscal agencies on March 1 of each year on the initial and follow-up surveys conducted on all nursing homes in this state. The department shall include all of the following information in the report:

(a) The number of surveys conducted.

(b) The number requiring follow-up surveys.

(c) The average number of citations per nursing home for the most recent calendar year.

(d) The number of night and weekend complaints filed.

(e) The number of night and weekend responses to complaints conducted by the department.

(f) The average length of time for the department to respond to a complaint filed against a nursing home.

(g) The number and percentage of citations disputed through informal dispute resolution and independent informal dispute resolution.

(h) The number and percentage of citations overturned or modified, or both.

(i) The review of citation patterns developed under subsection (8).

(j) Information regarding the progress made on implementing

the administrative and electronic support structure to efficiently coordinate all nursing home licensing and certification functions.

(k) The number of annual standard surveys of nursing homes that were conducted during a period of open survey or enforcement cycle.

(*l*) The number of abbreviated complaint surveys that were not conducted on consecutive surveyor workdays.

(m) The percent of all form CMS-2567 reports of findings that were released to the nursing home within the 10-working-day requirement.

(n) The percent of provider notifications of acceptance or rejection of a plan of correction that were released to the nursing home within the 10-working-day requirement.

(o) The percent of first revisits that were completed within 60 days from the date of survey completion.

(p) The percent of second revisits that were completed within 85 days from the date of survey completion.

(q) The percent of letters of compliance notification to the nursing home that were released within 10 working days of the date of the completion of the revisit.

(r) A summary of the discussions from the meetings required in subsection (24).

(s) The number of nursing homes that participated in a recognized quality improvement program as described under section 20155a(3).

(21) The department shall report **on** March 1 of each year to the standing committees on appropriations and the standing committees having jurisdiction over issues involving senior citizens in the senate and the house of representatives on all of

the following:

(a) The percentage of nursing home citations that are appealed through the informal dispute resolution process.

(b) The number and percentage of nursing home citations that are appealed and supported, amended, or deleted through the informal dispute resolution process.

(c) A summary of the quality assurance review of the amended citations and related survey retraining efforts to improve consistency among surveyors and across the survey administrative unit that occurred in the year being reported.

(22) Subject to subsection (23), a clarification work group comprised of the department in consultation with a nursing home resident or a member of a nursing home resident's family, nursing home provider groups, the American Medical Directors Association, the state long-term care ombudsman, and the federal Centers for Medicare and Medicaid Services shall clarify the following terms as those terms are used in title XVIII and title XIX and applied by the department to provide more consistent regulation of nursing homes in this state:

(a) Immediate jeopardy.

(b) Harm.

(c) Potential harm.

(d) Avoidable.

(e) Unavoidable.

(23) All of the following clarifications developed under subsection (22) apply for purposes of subsection (22):

(a) Specifically, the term "immediate jeopardy" means a situation in which immediate corrective action is necessary because the nursing home's noncompliance with 1 or more requirements of

participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident receiving care in a nursing home.

(b) The likelihood of immediate jeopardy is reasonably higher if there is evidence of a flagrant failure by the nursing home to comply with a peer-reviewed, evidence-based, nationally recognized clinical process guideline than if the nursing home has substantially and continuously complied with peer-reviewed, evidence-based, nationally recognized guidelines. If federal regulations and guidelines are not clear, and if the clinical process guidelines have been recognized, a process failure giving rise to an immediate jeopardy may involve an egregious widespread or repeated process failure and the absence of reasonable efforts to detect and prevent the process failure.

(c) In determining whether or not there is immediate jeopardy, the survey agency should consider at least all of the following:

(*i*) Whether the nursing home could reasonably have been expected to know about the deficient practice and to stop it, but did not stop the deficient practice.

(*ii*) Whether the nursing home could reasonably have been expected to identify the deficient practice and to correct it, but did not correct the deficient practice.

(*iii*) Whether the nursing home could reasonably have been expected to anticipate that serious injury, serious harm, impairment, or death might result from continuing the deficient practice, but did not so anticipate.

(*iv*) Whether the nursing home could reasonably have been expected to know that a widely accepted high-risk practice is or could be problematic, but did not know.

(*v*) Whether the nursing home could reasonably have been expected to detect the process problem in a more timely fashion, but did not so detect.

(d) The existence of 1 or more of the factors described in subdivision (c), and especially the existence of 3 or more of those factors simultaneously, may lead to a conclusion that the situation is one in which the nursing home's practice makes adverse events likely to occur if immediate intervention is not undertaken, and therefore constitutes immediate jeopardy. If none of the factors described in subdivision (c) is present, the situation may involve harm or potential harm that is not immediate jeopardy.

(e) Specifically, "actual harm" means a negative outcome to a resident that has compromised the resident's ability to maintain or reach, or both, his or her highest practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. Harm does not include a deficient practice that only may cause or has caused limited consequences to the resident.

(f) For purposes of subdivision (e), in determining whether a negative outcome is of limited consequence, if the ~~"state operations manual"~~ **"State Operations Manual"** or ~~"the guidance to surveyors"~~ **"The Guidance to Surveyors"** published by the federal Centers for Medicare and Medicaid Services does not provide specific guidance, the department may consider whether most people in similar circumstances would feel that the damage was of such short duration or impact as to be inconsequential or trivial. In such a case, the consequence of a negative outcome may be considered more limited if it occurs in the context of overall procedural consistency with a peer-reviewed, evidence-based,

nationally recognized clinical process guideline, as compared to a substantial inconsistency with or variance from the guideline.

(g) For purposes of subdivision (e), if the publications described in subdivision (f) do not provide specific guidance, the department may consider the degree of a nursing home's adherence to a peer-reviewed, evidence-based, nationally recognized clinical process guideline in considering whether the degree of compromise and future risk to the resident constitutes actual harm. The risk of significant compromise to the resident may be considered greater in the context of substantial deviation from the guidelines than in the case of overall adherence.

(h) To improve consistency and to avoid disputes over avoidable and unavoidable negative outcomes, nursing homes and survey agencies must have a common understanding of accepted process guidelines and of the circumstances under which it can reasonably be said that certain actions or inactions will lead to avoidable negative outcomes. If the ~~"state operations manual"~~ **"State Operations Manual"** or ~~"the guidance to surveyors"~~ **"The Guidance to Surveyors"** published by the federal Centers for Medicare and Medicaid Services is not specific, a nursing home's overall documentation of adherence to a peer-reviewed, evidence-based, nationally recognized clinical process guideline with a process indicator is relevant information in considering whether a negative outcome was avoidable or unavoidable and may be considered in the application of that term.

(24) The department shall conduct a quarterly meeting and invite appropriate stakeholders. The department shall invite as appropriate stakeholders under this subsection at least 1 representative from each nursing home provider organization that

does not own or operate a nursing home representing 30 or more nursing homes statewide, the state long-term care ombudsman or his or her designee, and any other clinical experts. Individuals who participate in these quarterly meetings, jointly with the department, may designate advisory workgroups to develop recommendations on the discussion topics that ~~should~~ **must** include, at a minimum, all of the following:

(a) Opportunities for enhanced promotion of nursing home performance, including, but not limited to, programs that encourage and reward providers that strive for excellence.

(b) Seeking quality improvement to the survey and enforcement process, including clarifications to process-related policies and protocols that include, but are not limited to, all of the following:

(*i*) Improving the surveyors' quality and preparedness.

(*ii*) Enhanced communication between regulators, surveyors, providers, and consumers.

(*iii*) Ensuring fair enforcement and dispute resolution by identifying methods or strategies that may resolve identified problems or concerns.

(c) Promoting transparency across provider and surveyor communities, including, but not limited to, all of the following:

(*i*) Applying regulations in a consistent manner and evaluating changes that have been implemented to resolve identified problems and concerns.

(*ii*) Providing consumers with information regarding changes in policy and interpretation.

(*iii*) Identifying positive and negative trends and factors contributing to those trends in the areas of resident care,

deficient practices, and enforcement.

(d) Clinical process guidelines.

(25) A nursing home shall use peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources to develop and implement resident care policies and compliance protocols with measurable outcomes specifically in the following clinical practice areas:

(a) Use of bed rails.

(b) Adverse drug effects.

(c) Prevention of falls.

(d) Prevention of pressure ulcers.

(e) Nutrition and hydration.

(f) Pain management.

(g) Depression and depression pharmacotherapy.

(h) Heart failure.

(i) Urinary incontinence.

(j) Dementia care.

(k) Osteoporosis.

(*l*) Altered mental states.

(m) Physical and chemical restraints.

(n) Person-centered care principles.

(26) In an area of clinical practice that is not listed in subsection (25), a nursing home may use peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources to develop and implement resident care policies and compliance protocols with measurable outcomes to promote performance excellence.

(27) The department shall consider recommendations from an advisory workgroup created under subsection (24). The department

may include training on new and revised peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources, which contain measurable outcomes, in the joint provider and surveyor training sessions to assist provider efforts toward improved regulatory compliance and performance excellence and to foster a common understanding of accepted peer-reviewed, evidence-based, best-practice resources between providers and the survey agency. The department shall post on its website all peer-reviewed, evidence-based, nationally recognized clinical process guidelines and peer-reviewed, evidence-based, best-practice resources used in a training session under this subsection for provider, surveyor, and public reference.

(28) Representatives from each nursing home provider organization that does not own or operate a nursing home representing 30 or more nursing homes statewide and the state long-term care ombudsman or his or her designee are permanent members of a clinical advisory workgroup created under subsection (24). The department shall issue survey certification memorandums to providers to announce or clarify changes in the interpretation of regulations.

(29) The department shall maintain the process by which the director of the long-term care division or his or her designee reviews and authorizes the issuance of a citation for immediate jeopardy or substandard quality of care before the statement of deficiencies is made final. The review must ~~assure~~ **ensure** the consistent and accurate application of federal and state survey protocols and defined regulatory standards. As used in this subsection, "immediate jeopardy" and "substandard quality of care"

mean those terms as defined by the federal Centers for Medicare and Medicaid Services.

(30) Upon availability of funds, the department shall give grants, awards, or other recognition to nursing homes to encourage the rapid development and implementation of resident care policies and compliance protocols that are created from peer-reviewed, evidence-based, nationally recognized clinical process guidelines or peer-reviewed, evidence-based, best-practice resources with measurable outcomes to promote performance excellence.

(31) A nursing home shall post the nursing home's survey report in a conspicuous place within the nursing home for public review.

(32) Nothing in this section limits the requirements of related state and federal law.

(33) As used in this section:

(a) "Consecutive days" means calendar days, but does not include Saturday, Sunday, or state- or federally-recognized holidays.

(b) "Form CMS-2567" means the federal Centers for Medicare and Medicaid Services' form for the statement of deficiencies and plan of correction or a successor form serving the same purpose.

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

(d) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-5.

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, 2023, except as otherwise provided in

this article, fees and assessments 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) Subject to subsection ~~(11),~~ **(10),** quality assurance assessment for nursing homes and hospital long-term care units	an amount resulting in not more than 6% of total industry revenues.
(h) Subject to subsection ~~(12),~~ **(11),** 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)~~ **(11)(a)** and (i).

(i) Initial licensure application fee for subdivisions (a), (b), (c), (e), and (f) .....$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, 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 do not lapse to the general fund but remain available to fund the certificate of need program in subsequent years.~~

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

(4) ~~(5)~~ Fees described in this section are payable to the department ~~at the time~~ **when** an application for a license ~~, permit,~~ or ~~certificate~~ **permit** is submitted. If an application for a license ~~,~~ **or** permit ~~, or certificate~~ is denied or if a license ~~,~~ **or** permit ~~, or certificate~~ is revoked before its expiration date, the department shall not refund fees paid to the department.

(5) ~~(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.

(6) ~~(7)~~ The cost of licensure activities must be supported by license fees.

(7) ~~(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 must be 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.

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

(9) ~~(10)~~ Except as otherwise provided in this section, the fees and assessments collected under this section must 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.

(10) ~~(11)~~ The quality assurance assessment collected under subsection (1)(g) and all federal matching funds attributed to that assessment 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 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) 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, 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) 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, must be assessed in the first quarter after federal approval of the waiver and 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), 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 quality assurance assessment collected under subsection (1)(g) must 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.

(j) In each fiscal year governed by this subsection, Medicaid reimbursement rates 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).

(k) The state retention amount of the quality assurance assessment collected under subsection (1)(g) must be 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 must be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2023, the department shall not assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection (1)(g) must not be assessed or collected 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 must be returned to the nursing home or hospital long-term care unit.

(11) ~~(12)~~ The quality assurance dedication is an earmarked assessment collected under subsection (1)(h). That assessment and

all federal matching funds attributed to that assessment 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 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), 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 quality assurance assessment must 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 (h).

(h) The quality assurance assessment collected under subsection (1)(h) must not be assessed or collected 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 must be returned to the hospital.

(i) The state retention amount of the quality assurance assessment collected under subsection (1)(h) must be 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. In the fiscal year ending September 30, 2017, there is a retention amount of $105,000,000.00 for the Healthy Michigan plan. Beginning in the fiscal year ending September 30, 2018, and

for each fiscal year thereafter, there is a retention amount of $118,420,600.00 for each fiscal year for the Healthy Michigan ~~Plan.~~ **plan.** The state retention percentage must be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds 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.

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

(a) The quality assurance assessment authorized under this subsection 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 must not exceed $20,000,000.00.

(d) The quality assurance assessment authorized under this subsection must not be collected after October 1, 2023. The quality assurance assessment authorized under this subsection must no

longer be collected or assessed if the quality assurance assessment authorized under this subsection is not eligible for federal matching funds.

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

(14) ~~(15)~~ As used in this section:

(a) "Healthy Michigan plan" means the medical assistance 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.~~**the program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5, and administered by the department of health and human services under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.**

Sec. 20164. (1) A license, certification, provisional license, or limited license is valid for not more than 1 year after the date of issuance, except as provided ~~in section 20511 or~~ **in** part 209. ~~or 210.~~ A license for a facility licensed under part 215 ~~shall be~~ **is** valid for 2 years, except that provisional and limited licenses may be valid for 1 year.

(2) A license ~~,~~ **or** certification ~~, or certificate of need~~ is not transferable and ~~shall~~ **must** state the persons, buildings, and properties to which it applies. ~~Applications for licensure or certification because of transfer of ownership or essential ownership interest shall not be acted upon until satisfactory evidence is provided of compliance with part 222.~~

(3) If ownership is not voluntarily transferred, the

department ~~shall~~ **must** be notified immediately and the new owner shall apply for a license and certification not later than 30 days after the transfer.

Sec. 20165. (1) Except as otherwise provided in this section, after notice of intent to an applicant or licensee to deny, limit, suspend, or revoke the applicant's or licensee's license or certification and an opportunity for a hearing, the department may deny, limit, suspend, or revoke the license or certification or impose an administrative fine on a licensee if 1 or more of the following exist:

(a) Fraud or deceit in obtaining or attempting to obtain a license or certification or in the operation of the licensed health facility or agency.

(b) A violation of this article or a rule promulgated under this article.

(c) False or misleading advertising.

(d) Negligence or failure to exercise due care, including negligent supervision of employees and subordinates.

(e) Permitting a license or certificate to be used by an unauthorized health facility or agency.

(f) Evidence of abuse regarding a patient's health, welfare, or safety or the denial of a patient's rights.

(g) Failure to comply with section 10115.

(h) Failure to comply with **former** part 222 or a term, condition, or stipulation of a certificate of need issued under **former** part 222, or both. **This subdivision only applies to a failure to comply that occurred before the effective date of the amendatory act that repealed part 222.**

(i) A violation of section 20197(1).

(2) The department may deny an application for a license or certification based on a finding of a condition or practice that would constitute a violation of this article if the applicant were a licensee.

(3) Denial, suspension, or revocation of an individual emergency medical services personnel license under part 209 is governed by section 20958.

(4) If the department determines under subsection (1) that a health facility or agency has violated section 20197(1), the department shall impose an administrative fine of $5,000,000.00 on the health facility or agency.

Sec. 20166. (1) Notice of intent to deny, limit, suspend, or revoke a license or certification ~~shall~~ **must** be given by certified mail or personal service, ~~shall~~ set forth the particular reasons for the proposed action, and ~~shall~~ fix a date, not less ~~that~~ **than** 30 days after the date of service, on which the applicant or licensee ~~shall be~~ **is** given the opportunity for a hearing before the director or the director's authorized representative. The hearing ~~shall~~ **must** be conducted in accordance with the administrative procedures act of 1969 and rules promulgated by the department. A full and complete record ~~shall~~ **must** be kept of the proceeding and ~~shall~~ **must** be transcribed when requested by an interested party, who shall pay the cost of preparing the transcript.

(2) On the basis of a hearing or on the default of the applicant or licensee, the department may issue, deny, limit, suspend, or revoke a license or certification. A copy of the determination ~~shall~~ **must** be sent by certified mail or served personally upon the applicant or licensee. The determination becomes final 30 days after it is mailed or served, unless the

applicant or licensee within the 30 days appeals the decision to the circuit court in the county of jurisdiction or to the Ingham ~~county~~ **County** circuit court.

(3) The department may establish procedures, hold hearings, administer oaths, issue subpoenas, or order testimony to be taken at a hearing or by deposition in a proceeding pending at any stage of the proceeding. A person may be compelled to appear and testify and to produce books, papers, or documents in a proceeding.

(4) In case of disobedience of a subpoena, a party to a hearing may invoke the aid of the circuit court of the jurisdiction in which the hearing is held to require the attendance and testimony of witnesses. The circuit court may issue an order requiring an individual to appear and give testimony. Failure to obey the order of the circuit court may be punished by the court as a contempt.

(5) The department shall not deny, limit, suspend, or revoke a license on the basis of an applicant's or licensee's failure to show a need for a health facility or agency unless the health facility or agency ~~has~~ **did** not ~~obtained~~ **obtain** a certificate of need **as** required by **former** part 222.

Sec. 21551. (1) A hospital licensed under this article and located in a nonurbanized area may apply to the department to temporarily delicense not more than 50% of its licensed beds for not more than 5 years.

(2) A hospital that is granted a temporary delicensure of beds under subsection (1) may apply to the department for an extension of temporary delicensure for those beds for up to an additional 5 years to the extent that the hospital actually ~~met the requirements of~~ **used the delicensed beds as described in** subsection (6) during

the initial period of delicensure granted under subsection (1). ~~The department shall grant an extension under this subsection unless the department determines under part 222 that there is a demonstrated need for the delicensed beds in the subarea in which the hospital is located.~~ If the department does not grant an extension under this subsection, the hospital shall request relicensure of the beds ~~pursuant to~~ **under** subsection (7) or allow the beds to become permanently delicensed ~~pursuant to~~ **under** subsection (8).

(3) Except as otherwise provided in this section, for a period of 90 days after January 1, 1991, if a hospital is located in a distressed area and has an annual indigent volume consisting of not less than 25% indigent patients, the hospital may apply to the department to temporarily delicense not more than 50% of its licensed beds for a period of not more than 2 years. Upon receipt of a complete application under this subsection, the department shall temporarily delicense the beds indicated in the application. The department shall not grant an extension of temporary delicensure under this subsection.

(4) An application under subsection (1) or (3) ~~shall~~ **must** be on a form provided by the department. The form ~~shall~~ **must** contain all of the following information:

(a) The number and location of the specific beds to be delicensed.

(b) The period of time during which the beds will be delicensed.

(c) The alternative use proposed for the space occupied by the beds to be delicensed.

(5) A hospital that files an application under subsection (1)

or (3) may file an amended application with the department on a form provided by the department. The hospital shall state on the form the purpose of the amendment. If the hospital meets the requirements of this section, the department shall so amend the hospital's original application.

(6) An alternative use of space made available by the delicensure of beds under this section shall not result in a violation of this article or the rules promulgated under this article. Along with the application, an applicant for delicensure under subsection (1) or (3) shall submit to the department plans that indicate to the satisfaction of the department that the space occupied by the beds proposed for temporary delicensure will be used for 1 or more of the following:

(a) An alternative use that over the proposed period of temporary delicensure would defray the depreciation and interest costs that otherwise would be allocated to the space along with the operating expenses related to the alternative use.

(b) To correct a licensing deficiency previously identified by the department.

(c) Nonhospital purposes including, but not limited to, community service projects, if the depreciation and interest costs for all capital expenditures that would otherwise be allocated to the space, as well as any operating costs related to the proposed alternative use, would not be considered as hospital costs for purposes of reimbursement.

(7) The department shall relicense beds that are temporarily delicensed under this section if all of the following requirements are met:

(a) The hospital files with the department a written request

for relicensure not less than 90 days before the earlier of the following:

(*i*) The expiration of the period for which delicensure was granted.

(*ii*) The date upon which the hospital is requesting relicensure.

(*iii*) The last hospital license renewal date in the delicensure period.

(b) The space to be occupied by the relicensed beds is in compliance with this article and the rules promulgated under this article, including all licensure standards in effect at the time of relicensure, or the hospital has a plan of corrections that has been approved by the department.

(8) If a hospital does not meet all of the requirements of subsection (7) or if a hospital decides to allow beds to become permanently delicensed as described in subsection (2), then all of the temporarily delicensed beds ~~shall~~ **must** be automatically and permanently delicensed effective on the last day of the period for which the department granted temporary delicensure.

(9) ~~The department shall continue to count beds temporarily delicensed under this section in the department's bed inventory for purposes of determining hospital bed need under part 222 in the subarea in which the beds are located.~~ The department shall indicate in the **department's** bed inventory which beds are licensed and which beds are ~~temporary~~ **temporarily** delicensed under this section. The department shall not include a hospital's temporarily delicensed beds in the hospital's licensed bed count.

~~(10) A hospital that is granted temporary delicensure of beds under this section shall not transfer the beds to another site or~~

~~hospital without first obtaining a certificate of need.~~

(10) ~~(11)~~ A hospital that has beds that are subject to a hospital bed reduction plan or to a department action to enforce this article shall not use beds temporarily delicensed under this section to comply with the bed reduction plan.

(11) ~~(12)~~ As used in this section:

(a) "Distressed area" means a city that meets all of the following criteria:

(*i*) Had a negative population change from 1970 to the date of the 1980 federal decennial census.

(*ii*) From 1972 to 1989, had an increase in its state equalized valuation that is less than the statewide average.

(*iii*) Has a poverty level that is greater than the statewide average, according to the 1980 federal decennial census.

(*iv*) Was eligible for an urban development action grant from the United States ~~department~~ **Department** of ~~housing~~ **Housing** and ~~urban development~~ **Urban Development** in 1984 and was listed in 49 ~~F.R.~~ **FR** No. 28 (February 9, 1984) or 49 ~~F.R.~~ **FR** No. 30 (February 13, 1984).

(*v*) Had an unemployment rate that was higher than the statewide average for 3 of the 5 years from 1981 to 1985.

(b) "Indigent volume" means the ratio of a hospital's indigent charges to its total charges expressed as a percentage as determined by the department of ~~social~~ **health and human** services after November 12, 1990, ~~pursuant to~~ **under** chapter 8 of the department of ~~social~~ **health and human** services guidelines entitled ~~"medical assistance program manual".~~**"Medical Assistance Program Manual".**

(c) "Nonurbanized area" means an area that is not an urbanized

area.

(d) "Urbanized area" means that term as defined by the ~~office~~ **Office** of ~~federal statistical policy~~ **Federal Statistical Policy** and ~~standards~~ **Standards** of the United States ~~department~~ **Department** of ~~commerce~~ **Commerce** in the appendix entitled ~~"general procedures and definitions",~~ **"General Procedures and Definitions"**, 45 ~~F.R. p.~~ **FR p.** 962 (January 3, 1980), which document is incorporated by reference.

Sec. 21562. (1) A hospital designated as a rural community hospital under section 21561 shall be a limited service hospital directed toward the delivery of not more than basic acute care services in order to ~~assure~~ **ensure** appropriate access in the rural area.

(2) The rules promulgated to implement this part ~~shall~~ **must** require that a hospital designated as a rural community hospital under section 21561 ~~shall~~ provide no more than the following services:

(a) Emergency care.

(b) Stabilization care for transfer to another facility.

(c) Inpatient care.

(d) Radiology and laboratory services.

(e) Ambulatory care.

(f) Obstetrical services.

(g) Outpatient services.

(h) Other services determined as appropriate by the ~~ad hoc advisory committee created in subsection (5).~~**department.**

(3) A rural community hospital shall enter into an agreement with the department of ~~social~~ **health and human** services to participate in the ~~medicaid~~ **Medicaid** program. As used in this

subsection, ~~"medicaid"~~ **"Medicaid"** means ~~that term as defined in section 22207.~~**the program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5, and administered by the department of health and human services under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.**

(4) A rural community hospital shall meet the conditions for participation in the federal ~~medicare~~ **Medicare** program under title XVIII of the social security act, **42 USC 1395 to 1395*lll*.**

~~(5) Not later than 3 months after the effective date of this section, the director shall appoint an ad hoc advisory committee to develop recommendations for rules to designate the maximum number of beds and the services to be provided by a rural community hospital. In developing recommendations under this subsection, the ad hoc advisory committee shall review the provisions of the code pertaining to hospital licensure in order to determine those provisions that should apply to rural community hospitals. The director shall direct the committee to report its recommendations to the department within 12 months after the committee is appointed. The ad hoc advisory committee shall be appointed as follows:~~

~~(a) Twenty-five percent of the members shall be representatives from hospitals with fewer than 100 licensed beds.~~

~~(b) Twenty-five percent of the members shall be representatives from health care provider organizations other than hospitals.~~

~~(c) Twenty-five percent of the members shall be representatives from organizations whose membership includes consumers of rural health care services or members of local governmental units located in rural areas.~~

~~(d) Twenty-five percent of the members shall be representatives from purchasers or payers of rural health care services.~~

(5) ~~(6)~~ A hospital designated as a rural community hospital under section 21561 shall develop and implement a transfer agreement between the rural community hospital and 1 or more appropriate referral hospitals.

Sec. 21563. (1) The department ~~, in consultation with the ad hoc advisory committee appointed under section 21562,~~ shall promulgate rules for designation of a rural community hospital, maximum number of beds, and the services provided by a rural community hospital. ~~The director shall submit proposed rules, based on the recommendations of the committee, for public hearing not later than 6 months after receiving the report under section 21562(5).~~

(2) The designation as a rural community hospital ~~shall~~ **must** be shown on a hospital's license and ~~shall~~ **must** be for the same term as the hospital license. Except as otherwise expressly provided in this part or in rules promulgated under this section, a rural community hospital ~~shall~~ **must** be licensed and regulated in the same manner as a hospital otherwise licensed under this article. ~~The provisions of part 222 applicable to hospitals also apply to a rural community hospital and to a hospital designated by the department under federal law as an essential access community hospital or a rural primary care hospital.~~ This part and the rules promulgated under this part do not preclude the establishment of differential reimbursement for rural community hospitals, essential access community hospitals, and rural primary care hospitals.

Enacting section 1. The following acts and parts of acts are

repealed:

(a) Section 20143 of the public health code, 1978 PA 368, MCL 333.20143.

(b) Section 21420 of the public health code, 1978 PA 368, MCL 333.21420.

(c) Part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

(d) Section 8t of 1945 PA 47, MCL 331.8t.

(e) Section 47 of the hospital finance authority act, 1969 PA 38, MCL 331.77.

Enacting section 2. This amendatory act takes effect 90 days after the date it is enacted into law.