Act No. 187
Public Acts of 2022
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STATE OF MICHIGAN
101ST LEGISLATURE
REGULAR SESSION OF 2022

Introduced by Reps. Kahle, O'Malley, Yaroch, Bellino, Bezotte and Whitsett

ENROLLED HOUSE BILL No. 5609

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 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," by amending sections 20102, 20104, 20155, 20161, 20164, 20171, 21734, 21763, 21764, 21771, 21794, and 21799b (MCL 333.20102, 333.20104, 333.20155, 333.20161, 333.20164, 333.20171, 333.21734, 333.21763, 333.21764, 333.21771, 333.21794, and 333.21799b), section 20102 as amended by 2010 PA 381, sections 20104, 20155, and 21734 as amended by 2015 PA 155, section 20161 as amended by 2020 PA 169, section 20164 as amended by 1990 PA 179, section 20171 as amended by 2014 PA 449, section 21763 as amended by 1996 PA 546, section 21771 as amended by 2012 PA 174, section 21794 as added by 2014 PA 529, and section 21799b as amended by 2000 PA 437, and by adding part 221; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

Sec. 20102. (1) "Aircraft transport operation" means that term as defined in section 20902.

(2) "Ambulance operation" means that term as defined in section 20902.

(3) "Attending physician" means the physician selected by, or assigned to, the patient and who has primary responsibility for the treatment and care of the patient.

(4) "Authorized representative" means the individual designated in writing by the board of directors of the corporation or by the owner or person with legal authority to act on behalf of the company or organization on licensing matters. The authorized representative who is not an owner or licensee shall not sign the original license application or amendments to the application.

Sec. 20104. (1) Except as otherwise provided in part 221, "certification" means the issuance of a document by the department to a health facility or agency attesting to the fact that the health facility or agency meets both of the following:

(a) It complies with applicable statutory and regulatory requirements and standards.

(b) It is eligible to participate as a provider of care and services in a specific federal or state health program.

(2) "Consumer" means a person who is not a health care provider as that term is defined in 42 USC 300jj.

(3) "County medical care facility" means a nursing care facility, other than a hospital long-term care unit, that provides organized nursing care and medical treatment to 7 or more unrelated individuals who are suffering or recovering from illness, injury, or infirmity and that is owned by a county or counties.

(4) "Department" means the department of licensing and regulatory affairs.

(5) "Direct access" means access to a patient or resident or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.

(6) "Director" means the director of the department.

(7) "Freestanding surgical outpatient facility" means a facility, other than the office of a physician, dentist, podiatrist, or other private practice office, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care. Freestanding surgical outpatient facility does not include a surgical outpatient facility owned by and operated as part of a hospital.

(8) "Good moral character" means that term as defined in, and determined under, 1974 PA 381, MCL 338.41 to 338.47.

Sec. 20155. (1) Except as otherwise provided in this section, 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 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 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. 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.

(8) Subject to subsection (11), 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 (10) 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 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 finding of substantial compliance or an accepted plan of correction, if applicable, on the most recent standard federal certification survey under part 221.

(9) Except as otherwise provided in subsection (13), accreditation information provided to the department under subsection (8) 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.

(10) The department shall grant a waiver under subsection (8) if the accreditation report submitted under subsection (8)(b) is less than 3 years old or the most recent standard federal certification survey under part 221 submitted under subsection (8)(c) shows substantial compliance or an accepted plan of correction, if applicable. If the accreditation report is too old, the department may deny the waiver request and conduct the visits required under subsection (8). Denial of a waiver request by the department is not subject to appeal.

(11) 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. 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.

(12) At the request of a health facility or agency other than a health facility or agency defined in section 20106(1)(a), (d), (h), and (i), the department may conduct a consultation engineering survey of that health facility or agency and provide professional advice and consultation regarding 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).

(13) 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 (8)(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.

(14) 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.

(15) 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 the assistance of a health facility or agency to access the system to maximize data export.

(16) 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 licensee and the department must both agree to the voluntary inspection described in this subsection.

(17) 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.

(18) 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 opportunities for enhanced promotion of nursing home performance, including, but not limited to, programs that encourage and reward nursing homes that strive for excellence.

(19) 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.

(20) The department shall consider recommendations from an advisory workgroup created under subsection (18). 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.

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

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

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), 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), quality assurance assessment for hospitals.....	at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i).
(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:

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

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-6.

(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) Except as otherwise provided in this section, 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.

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

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

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

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

(8) The application fee for a waiver under section 21564 is $200.00 plus $40.00 per hour for the professional services and travel expenses directly related to processing the application. The travel expenses 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.

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

(10) Except as otherwise provided in this section, the 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.

(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 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.

(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. 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.

(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.

(e) Beginning November 1, 2020, and by November 1 of each year thereafter, the department shall send a notification to each ambulance operation that will be assessed the quality assurance assessment authorized under this subsection during the year in which the notification is sent.

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

(15) For the fiscal year ending September 30, 2020 only, $3,000,000.00 of the money in the certificate of need program is transferred to and must be deposited into the general fund.

(16) 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.

Sec. 20164. (1) Except as provided in part 209, a license, certification, provisional license, or limited license is valid for not more than 1 year after the date of issuance.

(2) A license, certification, or certificate of need is not transferable and 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 must not be acted upon until satisfactory evidence is provided of compliance with part 222.

(3) If ownership is not voluntarily transferred, the department must be notified immediately and the new owner shall apply for a license and certification not later than 30 days after the transfer.

Sec. 20171. (1) The department shall promulgate and enforce rules to implement this article, including rules necessary to enable a health facility or agency to qualify for and receive federal funds available for patient care or for projects involving new construction, additions, modernizations, or conversions.

(2) The rules applicable to health facilities or agencies must be uniform insofar as is reasonable.

(3) The rules must establish standards relating to:

(a) Ownership.

(b) Reasonable disclosure of ownership interests in proprietary corporations and of financial interests of trustees of voluntary, nonprofit corporations and owners of proprietary corporations and partnerships.

(c) Organization and function of the health facility or agency, owner, operator, and governing body.

(d) Administration.

(e) Professional and nonprofessional staff, services, and equipment appropriate to implement section 20141(3).

(f) Policies and procedures.

(g) Fiscal and medical audit.

(h) Utilization and quality control review.

(i) Physical plant including planning, construction, functional design, sanitation, maintenance, housekeeping, and fire safety.

(j) Arrangements for the continuing evaluation of the quality of health care provided.

(k) Other pertinent organizational, operational, and procedural requirements for each type of health facility or agency.

(4) The rules promulgated under section 21563 for the designation of rural community hospitals may also specify all of the following:

(a) Maximum bed size.

(b) The level of services to be provided in each category as described in section 21562(2).

(c) Requirements for transfer agreements with other hospitals to ensure efficient and appropriate patient care.

(5) Rules promulgated under this article are subject to section 17 of the continuing care community disclosure act, 2014 PA 448, MCL 554.917.

Sec. 21734. (1) Notwithstanding section 20201(2)(*l*), a nursing home shall give each resident who uses a hospital-type bed or the resident's legal guardian, patient advocate, or other legal representative the option of having bed rails. A nursing home shall offer the option to new residents on admission and to other residents on request. On the receipt of a request for bed rails, the nursing home shall inform the resident or the resident's legal guardian, patient advocate, or other legal representative of alternatives to and the risks involved in using bed rails. A resident or the resident's legal guardian, patient advocate, or other legal representative has the right to request and consent to bed rails for the resident. A nursing home shall provide bed rails to a resident only on the receipt of a signed consent form authorizing bed rail use and a written order from the resident's attending physician that contains statements and determinations regarding medical symptoms and that specifies the circumstances under which bed rails are to be used. For purposes of this subsection, "medical symptoms" includes the following:

(a) A concern for the physical safety of the resident.

(b) Physical or psychological need expressed by a resident. A resident's fear of falling may be the basis of a medical symptom.

(2) A nursing home that provides bed rails under subsection (1) shall do all of the following:

(a) Document that the requirements of subsection (1) have been met.

(b) Monitor the resident's use of the bed rails.

(c) In consultation with the resident, resident's family, resident's attending physician, and individual who consented to the bed rails, periodically reevaluate the resident's need for the bed rails.

(3) The department shall maintain clear and uniform peer-reviewed, evidence-based, best-practice resources to be used in determining what constitutes each of the following:

(a) Acceptable bed rails for use in a nursing home in this state. The department shall consider the recommendations of the hospital bed safety work group established by the United States Food and Drug Administration, if those are available, in determining what constitutes an acceptable bed rail.

(b) Proper maintenance of bed rails.

(c) Properly fitted mattresses.

(d) Other hazards created by improperly positioned bed rails, mattresses, or beds.

(4) The department shall maintain the peer-reviewed, evidence-based, best-practice resources under subsection (3) in consultation with the long-term care stakeholders work group established under section 20155(18).

(5) A nursing home that complies with subsections (1) and (2) and the peer-reviewed, evidence-based, best-practices resources maintained under this section in providing bed rails to a resident is not subject to administrative penalties imposed by the department based solely on providing the bed rails. This subsection does not preclude the department from citing specific state or federal deficiencies for improperly maintained bed rails, improperly fitted mattresses, or other hazards created by improperly positioned bed rails, mattresses, or beds.

Sec. 21763. (1) A nursing home shall permit a representative of an approved organization, who is known by the nursing home administration to be authorized to represent the organization or who carries identification showing that the representative is authorized to represent the organization, a family member of a patient, or a legal representative of a patient, to have access to nursing home patients for 1 or more of the following purposes:

(a) Visit, talk with, and make personal, social, and legal services available to the patients.

(b) Inform patients of their rights and entitlements, and their corresponding obligations, under federal and state laws by means of the distribution of educational materials and discussion in groups and with individual patients.

(c) Assist patients in asserting their legal rights regarding claims for public assistance, medical assistance, and social services benefits, as well as in all matters in which patients are aggrieved. Assistance may be provided individually or on a group basis and may include organizational activity and counseling and litigation.

(d) Engage in other methods of assisting, advising, and representing patients so as to extend to them the full enjoyment of their rights.

(2) Access as prescribed in subsection (1) must be permitted during regular visiting hours each day. A representative of an approved organization entering a nursing home under this section promptly shall advise the nursing home administrator or the acting administrator or other available agent of the nursing home of the representative's presence. A representative shall not enter the living area of a patient without identifying himself or herself to the patient and without receiving the patient's permission to enter. A representative shall use only patient areas of the home to carry out the activities described in subsection (1).

(3) A patient may terminate a visit by a representative permitted access under subsection (1). Communications between a patient and the representative are confidential, unless otherwise authorized by the patient.

(4) If a nursing home administrator or employee believes that an individual or organization permitted access under this section is acting or has acted in a manner detrimental to the health or safety of patients in the nursing home, the nursing home administrator or employee may file an anonymous complaint with the department. On the receipt of a complaint, department staff shall investigate the allegations made in the complaint. The department shall make a determination regarding proper resolution of the complaint based on the results of the investigation. Written notification of the department's determination and recommendations shall be given to the complainant and the individual or organization against whom the complaint was made.

(5) An individual shall not enter upon the premises of a nursing home for the purpose of engaging in an activity that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested and that actually causes a nursing home employee, patient, or visitor to feel terrorized, frightened, intimidated, threatened, harassed, or molested. This subsection does not prohibit constitutionally protected activity or conduct that serves a legitimate purpose including, but not limited to, activities or conduct allowed under subsection (1).

Sec. 21764. (1) The director shall approve or disapprove a nonprofit corporation which has as 1 of its primary purposes the rendering of assistance, without charge to nursing home patients for the purpose of obtaining access to nursing homes and their patients under section 21763.

(2) On the receipt of a written application for approval under subsection (1), the director shall notify all persons that have made a written request for notice of applications made under this section.

(3) The director shall approve the organization making the request if the organization is a bona fide community organization or legal aid program, is capable of providing 1 or more of the services listed in section 21763, and is likely to utilize the access provided under section 21763 to enhance the welfare of nursing home patients. The director shall approve or disapprove the organization within 30 days after receiving the application.

Sec. 21771. (1) A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a patient.

(2) A nursing home employee who has reasonable suspicion of an act prohibited by this section shall report the suspicion to the nursing home administrator or nursing director and to the department as required by federal regulations. A nursing home administrator or nursing director who has reasonable suspicion of an act prohibited by this section shall report the suspicion by telephone to the department and 1 or more law enforcement entities as required by federal regulations.

(3) Any individual may report a violation of this section to the department.

(4) A physician or other licensed health care personnel who has reasonable suspicion of an act prohibited by this section shall report the suspicion to the department and 1 or more law enforcement entities as required by federal regulations.

(5) On the receipt of a report made under this section, the department shall make an investigation. The department may require the individual making the report to submit a written report or to supply additional information, or both.

(6) A nursing home employee, licensee, or nursing home administrator shall not evict, harass, dismiss, or retaliate against a patient, a patient's representative, or an employee who makes a report under this section.

(7) An individual required to report an act or a reasonable suspicion under subsection (2) or (4) is not required to report the act or suspicion to the department or 1 or more local law enforcement entities if the individual knows that another individual has already reported the act or suspicion as required by this section.

Sec. 21794. (1) With the consent of the patient or the patient's representative a nursing home may use a dining assistant to provide feeding assistance to a patient who, based on the charge nurse's assessment of the patient

and the patient's most recent plan of care, needs assistance or encouragement with eating and drinking, but does not have complicated feeding problems, including, but not limited to, difficulty swallowing, recurrent lung aspirations, tube or parenteral feedings, or behavioral issues that may compromise nutritional intake. The charge nurse's assessment and plan of care must be documented in the patient's medical record. For a patient who is assigned a dining assistant and experiences an emergent change in condition, the charge nurse shall perform a special assessment to monitor the appropriateness of continued utilization of the dining assistant.

(2) A nursing home that chooses to utilize dining assistants shall provide individuals with training through a department-approved training curriculum. The department and the long-term care stakeholder advisory workgroup designated under section 20155(18) shall develop a dining assistants training curriculum. The department shall approve a dining assistants training curriculum that meets the requirements of this subsection. In order to be approved by the department, the dining assistants training curriculum must include, at a minimum, 8 hours of course material that covers all of the following:

(a) Dining assistants program overview.

(b) Patient rights.

(c) Communication and interpersonal skills.

(d) Appropriate responses to patient behavior.

(e) Recognizing changes in patients.

(f) Infection control.

(g) Assistance with feeding and hydration.

(h) Feeding techniques.

(i) Safety and emergency procedures.

(j) End of life.

(3) An individual shall not provide feeding assistance as a dining assistant in a nursing home unless he or she has successfully completed a dining assistants training curriculum described in subsection (2). A nursing home shall not employ or allow an individual who is less than 17 years of age to provide feeding assistance as a dining assistant.

(4) A dining assistant shall work under the supervision of a nurse. A dining assistant's sole purpose is to provide feeding assistance to patients, and he or she shall not perform any other nursing or nursing-related services, such as toileting or transporting patients. A dining assistant is not nursing personnel and a nursing home shall not include a dining assistant in computing the ratio of patients to nursing personnel or use a dining assistant to supplement or replace nursing personnel. If approved by the charge nurse and subject to subsection (1), a dining assistant may provide feeding assistance in a patient's room if the patient is unable to go to or chooses not to dine in a designated dining area. A nurse is not required to be physically present within the patient's room during the feeding, but a nurse must be immediately available. A dining assistant who is providing feeding assistance to a patient in his or her room as provided under this subsection must not be assigned to assist another patient at the same time.

(5) Dining assistants are subject to the criminal history checks required under section 20173a.

(6) A nursing home that utilizes dining assistants shall maintain a written record of each individual used as a dining assistant. The nursing home shall include in the written record, at a minimum, the complete name and address of the individual, the date the individual successfully completed the dining assistants training curriculum, a copy of the written record of the satisfactory completion of the training curriculum, and documentation of the criminal history check.

(7) This section does not prohibit a family member or friend from providing feeding assistance to a patient within the nursing home or require a friend or family member to complete the training program prescribed under subsection (2). However, a nursing home may offer to provide the dining assistants training curriculum to family members and friends.

(8) As used in this section:

(a) "Dining assistant" means an individual who meets the requirements of this section and who is only paid to provide feeding assistance to nursing home patients by the nursing home or who is used under an arrangement with another agency or organization.

(b) "Immediately available" means being capable of responding to provide help if needed to the dining assistant at any time either in person or by voice or call light system, radio, telephone, pager, or other method of communication during a feeding.

(c) "Nurse" means an individual licensed as a registered professional nurse or a licensed practical nurse under article 15 to engage in the practice of nursing.

(d) "Under the supervision of a nurse" means that a nurse who is overseeing the work of a dining assistant is physically present in the nursing home and immediately available.

Sec. 21799b. (1) If, upon investigation, the department finds that a licensee is not in compliance with this part, a rule promulgated under this part, or a federal law or regulation governing nursing home certification under title XVIII or XIX, which noncompliance impairs the ability of the licensee to deliver an acceptable level of care and services, or in the case of a nursing home closure, the department shall notify the department of health and human services of the finding and may issue 1 or more of the following correction notices to the licensee:

(a) Suspend the admission or readmission of patients to the nursing home.

(b) Reduce the licensed capacity of the nursing home.

(c) Selectively transfer patients whose care needs are not being met by the licensee.

(d) Initiate action to place the home in receivership as prescribed in section 21751.

(e) Require appointment at the nursing home's expense of a department approved temporary administrative advisor or a temporary clinical advisor, or both, with authority and duties specified by the department to assist the nursing home management and staff to achieve sustained compliance with required operating standards.

(f) Require appointment at the nursing home's expense of a department approved temporary manager with authority and duties specified by the department to oversee the nursing home's achievement of sustained compliance with required operating standards or to oversee the orderly closure of the nursing home.

(g) Issue a correction notice to the licensee and the department of health and human services describing the violation and the statute or rule violated and specifying the corrective action to be taken and the period of time in which the corrective action is to be completed. Upon issuance, the director shall cause to be published in a daily newspaper of general circulation in an area in which the nursing home is located notice of the action taken and the listing of conditions upon which the director's action is predicated.

(2) Within 72 hours after receipt of a notice issued under subsection (1), the licensee must be given an opportunity for a hearing on the matter. The director's notice shall continue in effect during the pendency of the hearing and any subsequent court proceedings. The hearing must be conducted in compliance with the administrative procedures act of 1969.

(3) A licensee who believes that a correction notice has been complied with may request a verification of compliance from the department. Not later than 72 hours after the licensee makes the request, the department shall investigate to determine whether the licensee has taken the corrective action prescribed in the notice under subsection (1)(g). If the department finds that the licensee has taken the corrective action and that the conditions giving rise to the notice have been alleviated, the department may cease taking further action against the licensee, or may take other action that the director considers appropriate.

(4) The department shall report annually to the house of representatives and senate standing committees on senior issues on the number of times the department appointed a temporary administrative advisor, temporary clinical advisor, and temporary manager as described in subsection (1)(e) or (f). The report must include whether the nursing home closed or remained open. The department may include this report with other reports made to fulfill legislative reporting requirements.

(5) If the department determines that a nursing home's patients can be safeguarded and provided with a safe environment, the department shall make its decisions concerning the nursing home's future operation based on a presumption in favor of keeping the nursing home open.

(6) As used in this section:

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

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-6.

PART 221. FEDERAL CERTIFICATION OF NURSING HOMES

Sec. 22101. (1) As used in this part:

(a) "Certification" means certification issued by the Centers for Medicare and Medicaid Services to a nursing home as evidence that the nursing home complies with requirements under federal law for participation in Medicare.

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

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

(d) "Immediate jeopardy" means that term as defined in the "state operations manual" published by the Centers for Medicare and Medicaid Services.

(e) "Informal dispute resolution process" means the process described in section 22115.

(2) In addition, article 1 contains general definitions and principles of construction applicable to all articles in this code and part 201 contains definitions applicable to this part.

Sec. 22102. (1) The department shall administer the certification process in this state in conformance with 42 USC 1395aa and the "mission and priority document" and "state operations manual" published by the Centers for Medicare and Medicaid Services.

(2) To the extent that there is a conflict between this part and federal law, federal law controls.

Sec. 22103. (1) The department shall implement a quality assurance monitoring process for the purposes of conducting the surveys described in this part for the purpose of certification. The quality assurance monitoring process must include the quality assurance review of citations as described in this part. The department shall establish an advisory workgroup to provide recommendations to the department on the quality assurance monitoring process. Subject to subsection (2), the advisory workgroup established under this section must include a representative from the department, representatives from nursing home provider organizations, the state long-term care ombudsman, and any other representative that the department considers necessary or appropriate. The advisory workgroup shall identify and make recommendations on improvements to the quality assurance monitoring process to ensure ongoing validity, reliability, and consistency of nursing home survey findings.

(2) 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 the advisory workgroup established under subsection (1). The department shall issue survey certification memorandums to providers to announce or clarify changes in the interpretation of regulations.

(3) The department shall ensure that each nursing home survey team conducting a standard survey is composed of an interdisciplinary group of professionals, at least 1 of whom must be a registered professional nurse. Other members of the survey team 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.

(4) The nursing home surveyors conducting a standard survey shall designate a quality assurance monitor. The individual designated as the quality assurance monitor shall ensure all of the following:

(a) That survey protocols from the Centers for Medicare and Medicaid Services are followed.

(b) That interpretive regulatory guidance issued by the Centers for Medicare and Medicaid Services is applied consistently and noncompliance with the interpretive regulatory guidance is documented in a clear and concise manner.

(c) An entrance and exit conference is conducted in accordance with survey procedural guidelines established by the Centers for Medicare and Medicaid Services.

(d) That the survey complies with this part.

Sec. 22105. (1) Except as otherwise provided in this subsection, the department shall limit the number of nursing home surveyors that conduct a standard survey to the recommended number of surveyors identified in survey procedural guidelines established by the Centers for Medicare and Medicaid Services. The department may exceed the recommended number of nursing home surveyors only for the reasons identified in the guidelines described in this subsection.

(2) The department shall limit the length of a nursing home standard survey to a reasonable duration. In determining what is a reasonable duration, the department shall consider the average length of surveys nationally.

Sec. 22107. (1) When preparing to conduct any standard survey, the department shall determine if there is an open survey cycle and make every reasonable effort to confirm that substantial compliance has been achieved by implementing the nursing home's accepted plan of correction before initiating the standard survey while maintaining the federal requirement for a standard survey interval and the state survey average of 12 months.

(2) All abbreviated complaint surveys must be conducted on consecutive days until complete. All form CMS-2567 reports of survey findings must be released to the nursing home within 10 consecutive days after completion of the exit date of the survey.

(3) Departmental notifications of acceptance or rejection of a nursing home's plan of correction must be reviewed and released to the nursing home within 10 consecutive days after the receipt of the plan of correction.

(4) A nursing-home-submitted plan of correction in response to any survey must have a completion date not to exceed 40 days from the exit date of the survey. If a nursing home has not received additional citations before a revisit occurs, the department shall conduct the first revisit not more than 60 days from the exit date of the survey.

(5) A letter of compliance notification to a nursing home must be released to the nursing home within 10 consecutive days after the exit date of all revisits.

Sec. 22109. If a deficient practice occurred at a nursing home after the most recent survey of the nursing home under this part and the deficient practice is no longer occurring in the nursing home, the department shall, on the request of the nursing home, evaluate the deficient practice. If the nursing home is not eligible for an evaluation based on requirements from the Centers for Medicare and Medicaid Services, the department shall provide written notice to the nursing home explaining the reason the evaluation cannot be not granted.

Sec. 22111. (1) The department shall maintain the process by which the director of the long-term care division of the department reviews and authorizes the issuance of a citation for immediate jeopardy or substandard quality of care before a statement of deficiencies is made final. The review must ensure the consistent and accurate application of federal and state survey protocols and defined regulatory standards.

(2) On the discovery of a potential immediate jeopardy, a nursing home surveyor shall communicate with the nursing home administrator, the director of nursing for the nursing home, or the medical director of the nursing home, if available, to review the issues of concern and to give the nursing home an opportunity to share any data or documentation that may have an impact on a decision by the department to authorize the issuance of a citation for immediate jeopardy. If a citation for immediate jeopardy is issued to a nursing home, the department shall do both of the following:

(a) Contact the nursing home, at least once per day, until the immediate jeopardy is abated.

(b) Ensure that at least 1 nursing home surveyor remains on-site at the nursing home until the immediate jeopardy is abated unless the department determines that having a nursing home surveyor on-site at the nursing home is not practical.

Sec. 22113. On the receipt of a request from a nursing home, the department shall conduct a desk review of a citation if the circumstances meet the requirements established by the Centers for Medicare and Medicaid Services for a desk review instead of an on-site revisit for a standard or abbreviated survey. If the department determines that the nursing home is not eligible for a desk review, the department shall notify the nursing home, in writing, with an explanation of why a desk review could not be conducted.

Sec. 22115. (1) A nursing home that is issued a citation may request an appeal of the citation through an informal dispute resolution process from a peer review organization approved by the department. The department shall adopt the recommendations of the peer review organization on whether to support, amend, or delete the citation.

(2) Each quarter, the department shall do both of the following:

(a) Conduct a quality assurance review of amended or deleted citations with the peer review organization described in this section for the purposes of identifying whether there is a need for additional training of nursing home surveyors or peer review organization staff.

(b) Use the findings from the informal dispute resolution process for identifying training topics for the joint provider and surveyor training sessions described in section 20155.

Sec. 22117. (1) Subject to subsection (2), the department shall develop and implement statewide reporting requirements for facility-reported incidents for any category required by federal regulations and at least all of the following additional categories:

(a) Elopements.

(b) Bruising.

(c) Repeated statements from residents with mental health behaviors.

(d) Resident-to-resident incidents with no harm.

(2) The reporting requirements developed by the department under this section must exclude the following:

(a) A resident-to-resident altercation if there is no change in emotional status or physical functioning of each resident involved in the altercation, including, but not limited to, no change in range of motion, toileting, eating, or ambulating.

(b) An injury of unknown origin if there is no change in emotional status or physical functioning of the resident with the injury, including, but not limited to, no change in range of motion, toileting, eating, or ambulating.

(c) An allegation made by a resident who has been diagnosed with a mental illness, including, but not limited to, psychosis or severe dementia, if the resident has a history of making false statements that are not based in reality and are documented in the resident's care plan, with interventions to protect the resident.

(d) An allegation if a thorough assessment does not substantiate the allegation.

(e) An allegation if the resident or the resident's legal guardian or other legal representative has been informed of the allegation, does not wish for the nursing home to report the allegation, and has received information on how to file a complaint with the department.

Sec. 22119. The department shall report by 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 number and percentage of nursing home citations that are appealed through the informal dispute resolution process and an independent 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 and an independent informal dispute resolution process.

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

(d) The number of nursing home complaints and facility reported incidents received by the department, grouped by county. The information described in this subdivision must be shared as part of the quality assurance monitoring process and reviewed by the advisory workgroup established under section 22103.

(e) The number of surveys conducted.

(f) The number requiring follow-up surveys.

(g) The average number of citations per nursing home.

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

(i) The review of citation patterns developed under section 20155(7).

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

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

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

(m) The percentage 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.

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

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

(p) The percentage 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.

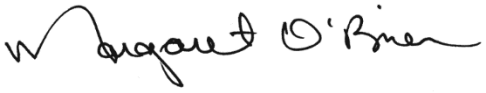
(q) A summary of the discussions from the meetings required in section 20155(18).

Sec. 22121. To the extent permitted by federal law, the department shall establish and implement progressive discretionary enforcement actions for the purposes of this part that consider the least restrictive enforcement action if a nursing home does not have a history of receiving citations in past nursing home surveys under this part and increase in severity if a nursing home has a history of receiving similar citations in past nursing home surveys under this part.

Enacting section 1. Sections 20121, 20122, 20123, 20124, 20126, 20127, 20155a, and 20211 of the public health code, 1978 PA 368, MCL 333.20121, 333.20122, 333.20123, 333.20124, 333.20126, 333.20127, 333.20155a, and 333.20211, are repealed.

This act is ordered to take immediate effect.

Clerk of the House of Representatives



Secretary of the Senate

Approved_____

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Governor