HOUSE BILL NO. 4723

July 01, 2025, Introduced by Rep. Witwer and referred to Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 20106, 20109, 20155, and 20161 (MCL 333.20106, 333.20109, 333.20155, and 333.20161), sections 20106 and 20161 as amended by 2024 PA 252, section 20109 as amended by 2015 PA 156, and section 20155 as amended by 2022 PA 187, and by adding part 219A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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

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

(b) A county medical care facility.

(c) A freestanding surgical outpatient facility.

~~(d) A health maintenance organization.~~

(d) ~~(e)~~ A home for the aged.

(e) ~~(f)~~ A hospital.

(f) ~~(g)~~ A nursing home.

(g) ~~(h)~~ A hospice.

(h) ~~(i)~~ A hospice residence.

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

(j) ~~(k)~~ A freestanding birth center.

(k) A supplemental nursing services agency.

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

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

community disclosure act, 2014 PA 448, MCL 554.917.

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

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

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

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

(a) A unit in a state correctional facility.

(b) A hospital.

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

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

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

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

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

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

(5) "Supplemental nursing services agency" means a person that is engaged for hire in the business of providing or procuring temporary employment in a health facility or agency for a nurse, nursing assistant, nurse aide, or orderly. Supplemental nursing services agency does not include either of the following:

(a) A person that provides staff to a home health agency as that term is defined in section 20173a.

(b) An individual if the individual is a nurse, nursing assistant, nurse aide, or orderly and the individual provides the individual's services as a nurse, nursing assistant, nurse aide, or orderly on a temporary basis to a health facility or agency.

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~~ **the nursing home surveyor's** 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~~ **the nursing home surveyor** 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~~ **the individual** 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~~ **the state long-term care ombudsman's** 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~~ **the pharmacist** 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),~~ **(g), and** (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~~ **the state long-term care ombudsman's** 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, 2027, 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	$500.00 per facility license and $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) Freestanding birth center	$500.00 per facility license.
(h) Subject to subsection (11), quality assurance assessment for nursing homes and hospital long-term care units	an amount resulting in not more

	than 6% of total industry revenues.
(i) Subject to subsection (12), quality assurance assessment for hospitals	at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i).
(j) Initial licensure application fee for subdivisions (a), (b), (c), (d), (e), (f), ~~and~~ (g), **and (k)**	$2,000.00 per initial license.
(k) Supplemental nursing services agencies	**$2,000.00 per agency 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-8.

(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)(h) 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)(h) in accordance with subdivision (c)(*i*) or in accordance with a written payment agreement with this state shall not receive the increased per diem Medicaid reimbursement rates under this subdivision until all of its outstanding quality assurance assessments and any penalties assessed under subdivision (f) have been paid in full. This subdivision does not authorize or require the department to overspend tax revenue in violation of the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

(b) Except as otherwise provided under subdivision (c), beginning October 1, 2005, the quality assurance assessment is based on the total number of patient days of care each nursing home and hospital long-term care unit provided to non-Medicare patients within the immediately preceding year, 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)(h) less the total amount to be paid by the nursing homes and long-term care units with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application by the total number of non-Medicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39 licensed beds, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, 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)(h), the department may assess the nursing home or hospital long-term care unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment.

The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

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

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

(i) The quality assurance assessment collected under subsection (1)(h) 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)(h).

(k) 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 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, 2027, 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)(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 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)(i). 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)(i), the department may assess the hospital a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

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

(g) In each fiscal year governed by this subsection, the quality assurance assessment must only be collected and expended if Medicaid hospital inpatient DRG and outpatient reimbursement rates 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)(i), except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection (1)(i) 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)(i) 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. Beginning in the fiscal year ending September 30, 2018, and for each fiscal year thereafter, there is a retention amount of at least $118,420,600.00 for each fiscal year for the Healthy Michigan plan. By May 31 of each year, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount 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.

(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, 2027. 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) By November 1 of each year, 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) 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.

PART 219A

SUPPLEMENTAL NURSING SERVICES AGENCIES

Sec. 21951. (1) As used in this part:

(a) "Medicaid" means benefits under the program of medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-8, and administered by the department of health and human services under the social welfare act, 1939 PA

280, MCL 400.1 to 400.119b.

(b) "Medicare" means benefits under the federal Medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(c) "Nurse" means an individual who is licensed or otherwise authorized to engage in the practice of nursing or practice of nursing as a licensed practical nurse under part 172.

(d) "Nurse aide" means an individual who holds a registration under part 219 to practice as a nurse aide under the nurse aide training, registration, and permit program described in section 21907.

(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. 21953. (1) A supplemental nursing services agency must be licensed under this article.

(2) "Supplemental nursing services agency" or a similar term or abbreviation must not be used to describe or refer to a supplemental nursing services agency unless it is licensed under this article.

Sec. 21955. (1) In addition to any information required under section 20142, a person shall include, as part of its application for licensure as a supplemental nursing services agency, all of the following:

(a) The names, addresses, principal occupations, and official position of all persons who have an ownership interest in the supplemental nursing services agency.

(b) A policy or procedure describing how the supplemental nursing services agency's records will be immediately available at

all times to the department.

(c) Proof satisfactory to the department that the supplemental nursing services agency complies with all of the following:

(*i*) The supplemental nursing services agency documents that each nurse, nursing assistant, nurse aide, or orderly provided to a health facility or agency on a temporary basis by the supplemental nursing services agency meets the minimum licensing, training, and continuing education standards, as applicable, for the position in which the nurse, nursing assistant, nurse aide, or orderly will be working.

(*ii*) The supplemental nursing services agency ensures that each nurse, nursing assistant, nurse aide, or orderly provided to a health facility or agency on a temporary basis by the supplemental nursing services agency meets the qualifications of personnel employed in the health facility or agency in which the nurse, nursing assistant, nurse aide, or orderly is placed.

(*iii*) The supplemental nursing services agency demonstrates to the satisfaction of the department that each nurse, nursing assistant, nurse aide, and orderly provided to a health facility or agency by the supplemental nursing services agency is an employee of the supplemental nursing services agency.

(*iv*) The supplemental nursing services agency does not restrict the employment opportunities of a nurse, nursing assistant, nurse aide, or orderly who is employed by the supplemental nursing services agency.

(*v*) The supplemental nursing services agency does not, in a contract with a nurse, nursing assistant, nurse aide, or orderly, or a contract with a health facility or agency, require the payment of damages, employment fees, or other compensation if the nurse,

nursing assistant, nurse aide, or orderly is hired by the health facility or agency.

(*vi*) The requirements described in section 1003(2)(c) of the occupational code, 1980 PA 299, MCL 339.1003.

(2) A supplemental nursing services agency shall retain any records or documentation described in this section for the granting of a license for not less than 5 years after the date the license is granted by the department and shall make the records and documentation available to the department on the department's request.

(3) The owner, operator, and governing body of a supplemental nursing services agency licensed under this article shall cooperate with the department in the enforcement of this part.

Sec. 21957. (1) Subject to subsection (2), a supplemental nursing services agency shall not bill, or receive a payment from, a health facility or agency at a rate that is higher than 25% of the hourly wage rate paid to a nurse, nursing assistant, nurse aide, or orderly who is provided to the health facility or agency on a temporary basis by the supplemental nursing services agency.

(2) A payment by a health facility or agency for the actual travel and housing costs for a nurse, nursing assistant, nurse aide, or orderly described in subsection (1) that is received by the supplemental nursing services agency or the nurse, nursing assistant, nurse aide, or orderly must not be considered under subsection (1).

Sec. 21959. A supplemental nursing services agency shall submit a quarterly report to the department that contains all of the following information for each health facility or agency participating in Medicare or Medicaid with which the supplemental

nursing services agency contracts:

(a) A list of the average amount charged to the health facility or agency for each of the following categories of employees of the supplemental nursing services agency:

(*i*) Nurses.

(*ii*) Nursing assistants.

(*iii*) Nurse aides.

(*iv*) Orderlies.

(b) A list of the average amount paid by the supplemental nursing services agency to each of the following categories of employees of the supplemental nursing services agency:

(*i*) Nurses.

(*ii*) Nursing assistants.

(*iii*) Nurse aides.

(*iv*) Orderlies.

Sec. 21961. The department shall not enforce this part, including, but not limited to, the requirement that a supplemental nursing services agency be licensed under this article, until 6 months after the effective date of the amendatory act that added this part.