PUBLIC HEALTH CODE (EXCERPT)

Act 368 of 1978

333.20106 Definitions; H.

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 clinical laboratory.

(c) A county medical care facility.

(d) A freestanding surgical outpatient facility.

(e) A health maintenance organization.

(f) A home for the aged.

(g) A hospital.

(h) A nursing home.

(i) A hospice.

(j) A hospice residence.

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

(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, 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 60 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 60 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home.

(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 community health 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.

333.20155 Visits to health facilities and agencies, clinical laboratories, nursing homes, hospices, and hospitals; purposes; waiver; confidentiality of accreditation information; limitation and effect; consultation engineering survey; summary of substantial noncompliance or deficiencies and hospital response; investigations or inspections;

prior notice; misdemeanor; consultation visits; record; periodic reports; access to documents; confidentiality; disclosure; delegation of functions; voluntary inspections; forwarding evidence of violation to licensing agency; reports; clarification of terms; clinical process guidelines; clinical advisory committee; definitions.

Sec. 20155.

(1) Except as otherwise provided in this section, the department of consumer and industry services shall make annual and other visits to each health facility or agency licensed under this article for the purposes of survey, evaluation, and consultation. A visit made pursuant to a complaint shall 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 pursuant to a complaint are announced or unannounced. Beginning June 20, 2001, the department shall assure 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. A member of a survey team shall 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 5 years.

(2) The department of consumer and industry services shall make at least a biennial visit to each licensed clinical laboratory, each nursing home, and each hospice residence for the purposes of survey, evaluation, and consultation. The department of consumer and industry services 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 of consumer and industry services shall develop a protocol for the review of citation patterns compared to regional outcomes and standards and complaints regarding the nursing home survey process. The review will result in a report provided to the legislature. Except as otherwise provided in this subsection, beginning with his or her first full relicensure period after June 20, 2000, each member of a department of consumer and industry services 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.

(3) The department of consumer and industry services shall make a biennial visit to each hospital for survey and evaluation for the purpose of licensure. Subject to subsection (6), the department may waive the biennial visit required by this subsection if a hospital, as part of a timely application for license renewal, requests a waiver and submits both of the following and if all of the requirements of subsection (5) are met:

(a) Evidence that it is currently fully accredited by a body with expertise in hospital accreditation whose hospital accreditations are accepted by the United States department of health and human services for purposes of section 1865 of part C of title XVIII of the social security act, 42 U.S.C. 1395bb.

(b) A copy of the most recent accreditation report for the hospital issued by a body

described in subdivision (a), and the hospital's responses to the accreditation report.

(4) Except as provided in subsection (8), accreditation information provided to the department of consumer and industry services under subsection (3) 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 shall return the accreditation information to the hospital within a reasonable time after a decision on the waiver request is made.

(5) The department of consumer and industry services shall grant a waiver under subsection (3) if the accreditation report submitted under subsection (3)(b) is less than 2 years old and there is no indication of substantial noncompliance with licensure standards or of deficiencies that represent a threat to public safety or patient care in the report, in complaints involving the hospital, or in any other information available to the department. If the accreditation report is 2 or more years old, the department may do 1 of the following:

(a) Grant an extension of the hospital's current license until the next accreditation survey is completed by the body described in subsection (3)(a).

(b) Grant a waiver under subsection (3) based on the accreditation report that is 2 or more years old, on condition that the hospital promptly submit the next accreditation report to the department.

(c) Deny the waiver request and conduct the visits required under subsection (3).

(6) This section does not prohibit the department from citing a violation of this part during a survey, conducting investigations or inspections pursuant to section 20156, or conducting surveys of health facilities or agencies for the purpose of complaint investigations or federal certification. This section does not prohibit the state fire marshal from conducting annual surveys of hospitals, nursing homes, and county medical care facilities.

(7) At the request of a health facility or agency, the department of consumer and industry services may conduct a consultation engineering survey of a health facility and provide professional advice and consultation regarding health facility construction and design. A health facility or agency may request a voluntary consultation survey under this subsection at any time between licensure surveys. The fees for a consultation engineering survey are the same as the fees established for waivers under section 20161(10).

(8) If the department of consumer and industry services 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 pursuant to subsection (3)(b), the department shall prepare a written summary of the substantial noncompliance or deficiencies and the hospital's response to the department's determination. The department's written summary and the hospital's response are public documents.

(9) The department of consumer and industry services 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.

(10) The department of consumer and industry services shall maintain a record indicating whether a visit and inspection is announced or unannounced. Information gathered at each visit and inspection, whether announced or unannounced, shall be taken into account in licensure decisions.

(11) The department of consumer and industry services 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 respect the confidentiality of a patient's clinical record and shall not divulge or disclose the contents of the 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.

(12) The department of consumer and industry services may delegate survey, evaluation, or consultation functions to another state agency or to a local health department qualified to perform those functions. However, 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 delegation shall be by cost reimbursement contract between the department and the state agency or local health department. Survey, evaluation, or consultation functions shall not be delegated to nongovernmental agencies, except as provided in this section. The department may accept voluntary inspections performed by an accrediting body with expertise in clinical laboratory accreditation under part 205 if the accrediting body utilizes forms acceptable to the department, applies the same licensing standards as applied to other clinical laboratories and provides the same information and data usually filed by the department's own employees when engaged in similar inspections or surveys. The voluntary inspection described in this subsection shall be agreed upon by both the licensee and the department.

(13) If, upon investigation, the department of consumer and industry services 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.

(14) The department of consumer and industry services shall report to the appropriations subcommittees, the senate and house of representatives standing committees having jurisdiction over issues involving senior citizens, and the fiscal agencies on March 1 of each year on the initial and follow-up surveys conducted on all nursing homes in this state. The report shall include all of the following information:

(a) The number of surveys conducted.

(b) The number requiring follow-up surveys.

(c) The number referred to the Michigan public health institute for remediation.

(d) The number of citations per nursing home.

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

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

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

(h) The number and percentage of citations appealed.

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

(15) The department of consumer and industry services shall report annually 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 the percentage of nursing home citations that are appealed and the percentage of nursing home citations that are appealed and amended through the informal deficiency dispute resolution process.

(16) Subject to subsection (17), a clarification work group comprised of the department of consumer and industry services in consultation with a nursing home resident or a member of a nursing home resident's family, nursing home provider groups, the American medical directors association, the department of community health, the stat long-term care ombudsman, and the federal centers for medicare and medicaid services shall clarify the following terms as those terms are used in title XVIII and title XIX and applied by the department to provide more consistent regulation of nursing homes in Michigan:

(a) Immediate jeopardy.

(b) Harm.

(c) Potential harm.

(d) Avoidable.

(e) Unavoidable.

(17) All of the following clarifications developed under subsection (16) apply for purposes of subsection (16):

(a) Specifically, the term “immediate jeopardy” means “a situation in which immediate corrective action is necessary because the nursing home's noncompliance with 1 or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident receiving care in a nursing home”.

(b) The likelihood of immediate jeopardy is reasonably higher if there is evidence of a flagrant failure by the nursing home to comply with a clinical process guideline adopted under subsection (18) than if the nursing home has substantially and continuously complied with those guidelines. If federal regulations and guidelines are not clear, and if the clinical process guidelines have been recognized, a process failure giving rise to an immediate jeopardy may involve an egregious widespread or repeated process failure and the absence of reasonable efforts to detect and prevent the process failure.

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

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

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

(iii) Whether the nursing home could reasonably have been expected to anticipate that

serious injury, serious harm, impairment, or death might result from continuing the deficient practice, but did not so anticipate.

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

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

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

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

(f) For purposes of subdivision (e), in determining whether a negative outcome is of limited consequence, if the "state operations manual" or "the guidance to surveyors" published by the federal centers for medicare and medicaid services does not provide specific guidance, the department may consider whether most people in similar circumstances would feel that the damage was of such short duration or impact as to be inconsequential or trivial. In such a case, the consequence of a negative outcome may be considered more limited if it occurs in the context of overall procedural consistency with an accepted clinical process guideline adopted pursuant to subsection (18), as compared to a substantial inconsistency with or variance from the guideline.

(g) For purposes of subdivision (e), if the publications described in subdivision (f) do not provide specific guidance, the department may consider the degree of a nursing home's adherence to a clinical process guideline adopted pursuant to subsection (18) in considering whether the degree of compromise and future risk to the resident constitutes actual harm. The risk of significant compromise to the resident may be considered greater in the context of substantial deviation from the guidelines than in the case of overall adherence.

(h) To improve consistency and to avoid disputes over "avoidable" and "unavoidable" negative outcomes, nursing homes and survey agencies must have a common understanding of accepted process guidelines and of the circumstances under which it can reasonably be said that certain actions or inactions will lead to avoidable negative outcomes. If the "state operations manual" or "the guidance to surveyors" published by the federal centers for medicare and medicaid services is not specific, a nursing home's overall documentation of adherence to a clinical process guideline with a process indicator adopted pursuant to subsection (18) is relevant information in considering whether a negative outcome was "avoidable" or "unavoidable" and may be considered in the application of that term.

(18) Subject to subsection (19), the department, in consultation with the clarification work group appointed under subsection (16), shall develop and adopt clinical process guidelines that shall be used in applying the terms set forth in subsection (16). The department shall establish and adopt clinical process guidelines and compliance protocols with outcome measures for all of the following areas and for other topics where the department determines that clarification will benefit providers and consumers of long-term care:

(a) Bed rails.

(b) Adverse drug effects.

(c) Falls.

(d) Pressure sores.

(e) Nutrition and hydration including, but not limited to, heat-related stress.

(f) Pain management.

(g) Depression and depression pharmacotherapy.

(h) Heart failure.

(i) Urinary incontinence.

(j) Dementia.

(k) Osteoporosis.

(l) Altered mental states.

(m) Physical and chemical restraints.

(19) The department shall create a clinical advisory committee to review and make recommendations regarding the clinical process guidelines with outcome measures adopted under subsection (18). The department shall appoint physicians, registered professional nurses, and licensed practical nurses to the clinical advisory committee, along with professionals who have expertise in long-term care services, some of whom may be employed by long-term care facilities. The clarification work group created under subsection (16) shall review the clinical process guidelines and outcome measures after the clinical advisory committee and shall make the final recommendations to the department before the clinical process guidelines are adopted.

(20) The department shall create a process by which the director of the division of nursing home monitoring or his or her designee or the director of the division of operations or his or her designee reviews and authorizes the issuance of a citation for immediate jeopardy or substandard quality of care before the statement of deficiencies is made final. The review shall be to assure that the applicable concepts, clinical process guidelines, and other tools contained in subsections (17) to (19) are being used consistently, accurately, and effectively. As used in this subsection, “immediate jeopardy” and “substandard quality of care” mean those terms as defined by the federal centers for medicare and medicaid services.

(21) The department may give grants, awards, or other recognition to nursing homes to encourage the rapid implementation of the clinical process guidelines adopted under subsection (18).

(22) The department shall assess the effectiveness of the amendatory act that added this subsection. The department shall file an annual report on the implementation of the clinical process guidelines and the impact of the guidelines on resident care with the standing committee in the legislature with jurisdiction over matters pertaining to nursing homes. The first report shall be filed on July 1 of the year following the year in

which the amendatory act that added this subsection takes effect.

(23) The department of consumer and industry services shall instruct and train the surveyors in the use of the clarifications described in subsection (17) and the clinical process guidelines adopted under subsection (18) in citing deficiencies.

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

(25) Nothing in this amendatory act shall be construed to limit the requirements of related state and federal law.

(26) As used in this section:

(a) "Title XVIII" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

(b) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v.

333.20161 Fees for health facility and agency licenses and certificates of need; surcharge; fee for provisional license or temporary permit; fee to recover cost of proficiency evaluation samples; fee for reissuance of clinical laboratory license; cost of licensure activities; application fee for waiver under § 333.21564; travel expenses; fees for licensure or renewal under part 209; deposit of fees; use of quality assurance assessment fee; earmarking "medicaid" defined.

Sec. 20161.

(1) The department shall assess fees for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Except as otherwise provided in this article, fees shall be paid in accordance with the following fee schedule:

(a) Freestanding surgical outpatient facilities
$ 238.00 per facility.

(b) Hospitals
$ 8.28 per licensed bed.

(c) Nursing homes, county medical care facilities, and hospital long-term care units
$ 2.20 per licensed bed.

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

(e) Clinical laboratories
$ 475.00 per laboratory.

(f) Hospice residences
$ 200.00 per license survey; and $20.00 per licensed bed.

(g) Subject to subsection (13), quality assurance assessment fee for nongovernmentally owned nursing homes and hospital long-term care units
an amount resulting in not

more than a 7% increase in aggregate medicaid nursing home and hospital long-term care unit payment rates, net of assessments, above the rates that were in effect on April 1, 2002.

(h) Subject to subsection (14), quality assurance assessment fee for hospitals at a rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (14)(a) and (k).

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

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

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

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

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

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

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

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

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

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

(12) The fees collected under this section shall be deposited in the state treasury, to the credit of the general fund.

(13) The quality assurance assessment fee collected under subsection (1)(g) and all federal matching funds attributed to that fee shall be used only for the following purposes and under the following specific circumstances:

(a) The quality assurance assessment fee and all federal matching funds attributed to that fee shall be used to maintain the increased per diem medicaid reimbursement rate increases as provided for in subdivision (e). Only licensed nursing homes and hospital long-term care units that are assessed the quality assurance assessment fee and participate in the medicaid program are eligible for increased per diem medicaid reimbursement rates under this subdivision.

(b) The quality assurance assessment fee shall be implemented on the effective date of the amendatory act that added this subsection.

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

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

(e) Upon implementation pursuant to subdivision (b), the department of community health shall increase the per diem nursing home medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment fee is assessed and collected, the department of community health shall maintain the medicaid nursing home reimbursement payment increase financed by the quality assurance assessment fee.

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

(g) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection (1)(g), the department of community health may assess the nursing home or hospital long-term care unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(h) The medicaid nursing home quality assurance assessment fund is established in the state treasury. The department of community health shall deposit the revenue raised through the quality assurance assessment fee with the state treasurer for deposit in the medicaid nursing home quality assurance assessment fund.

(i) Neither the department of consumer and industry services nor the department of community health shall implement this subsection in a manner that conflicts with 42 U.S.C. 1396b(w).

(j) The quality assurance assessment fee collected under subsection (1)(g) shall be prorated on a quarterly basis for any licensed beds added to or subtracted from a

nursing home or hospital long-term care unit since the immediately preceding July 1. Any adjustments in payments are due on the next quarterly installment due date.

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

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

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

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

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

(b) The quality assurance assessment fee shall be implemented on the effective date of the amendatory act that added this subsection.

(c) The quality assurance assessment fee shall be assessed on all net patient revenue, before deduction of expenses, less medicare net revenue, as reported in the most recently available medicare cost report and is payable on a quarterly basis, the first payment due 90 days after the date the fee is assessed. As used in this subdivision, "medicare net revenue" includes medicare payments and amounts collected for coinsurance and deductibles.

(d) Upon implementation pursuant to subdivision (b), the department of community

health shall increase the hospital medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment fee is assessed and collected, the department of community health shall maintain the hospital medicaid reimbursement rate increase financed by the quality assurance assessment fees.

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

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

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

(h) In each fiscal year governed by this subsection, the quality assurance assessment fee shall only be collected and expended if medicaid hospital inpatient DRG and outpatient reimbursement rates and disproportionate share hospital and graduate medical education payments are not below the level of rates and payments in effect on April 1, 2002 as a direct result of the quality assurance assessment fee collected under subsection (1)(h), except as provided in subdivision (j).

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

MEDICAL SERVICES

Hospital services and therapy

$ 149,200,000

Gross appropriation

$ 149,200,000

Appropriated from:

Federal revenues:

Total federal revenues

82,686,800

Special revenue funds:

Medicaid quality assurance assessment

66,513,500

Total local revenues

0

State general fund/general purpose

$ 0

(j) The quality assurance assessment fee collected under subsection (1)(h) shall no longer be assessed or collected after September 30, 2004, or in the event that the quality assurance assessment fee is not eligible for federal matching funds. Any

portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds shall be returned to the hospital.

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

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

333.21401 Definitions; principles of construction.

Sec. 21401.

(1) As used in this part:

(a) "Home care" means a level of care provided to a patient that is consistent with the categories "routine home care" or "continuous home care" described in 42 C.F.R. 418.302(b)(1) and (2).

(b) "Hospice residence" means a facility that meets all of the following:

(i) Provides 24-hour hospice care to 2 or more patients at a single location.

(ii) Either provides inpatient care directly in compliance with this article and with the standards set forth in 42 C.F.R. 418.100 or provides home care as described in this article.

(iii) Is owned, operated, and governed by a hospice program that is licensed under this article and provides aggregate days of patient care on a biennial basis to not less than 51% of its hospice patients in their own homes. As used in this subparagraph, "home" does not include a residence established by a patient in a health facility or agency licensed under this article or a residence established by a patient in an adult foster care facility licensed under the adult foster care facility licensing act, Act No. 218 of the Public Acts of 1979, being sections 400.701 to 400.737 of the Michigan Compiled Laws.

(c) "Inpatient care" means a level of care provided to a patient that is consistent with the categories "inpatient respite care day" and "general inpatient care day" described in 42 C.F.R. 418.302(b)(3) and (4).

(2) 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.

333.21413 Duties of owner, operator, and governing body of hospice or hospice residence.

Sec. 21413.

(1) The owner, operator, and governing body of a hospice or hospice residence licensed under this article:

(a) Are responsible for all phases of the operation of the hospice or hospice residence and for the quality of care and services rendered by the hospice or hospice residence.

(b) Shall cooperate with the department in the enforcement of this part, and require that the physicians and other personnel working in the hospice or hospice residence and for whom a license or registration is required be currently licensed or registered.

(c) Shall not discriminate because of race, religion, color, national origin, or sex, in the operation of the hospice or hospice residence including employment, patient admission and care, and room assignment.

(2) As a condition of licensure as a hospice residence, an applicant shall have been licensed under this article as a hospice and in compliance with the standards set forth in 42 C.F.R. part 418 for not less than the 2 years immediately preceding the date of application for licensure. A hospice residence licensed under this article may provide both home care and inpatient care at the same location. A hospice residence providing inpatient care shall comply with the standards in 42 C.F.R. 418.100.

(3) In addition to the requirements of subsections (1) and (2) and section 21415, the owner, operator, and governing body of a hospice residence that is licensed under this article and that provides care only at the home care level shall do all of the following:

(a) Provide 24-hour nursing services for each patient in accordance with the patient's hospice care plan as required under 42 C.F.R. part 418.

(b) Have an approved plan for infection control that includes making provisions for isolating each patient with an infectious disease.

(c) Obtain fire safety approval pursuant to section 20156.

(d) Equip each patient room with a device approved by the department for calling the staff member on duty.

(e) Design and equip areas within the hospice residence for the comfort and privacy of each patient and his or her family members.

(f) Permit patients to receive visitors at any hour, including young children.

(g) Provide individualized meal service plans in accordance with 42 C.F.R. 418.100(j).

(h) Provide appropriate methods and procedures for the storage, dispensing, and administering of drugs and biologicals pursuant to 42 C.F.R. 418.100(k).

333.21415 Program of planned and continuous hospice care; direction of medical components; coordination, design, and provision of hospice services.

Sec. 21415.

(1) A hospice or a hospice residence shall provide a program of planned and continuous hospice care, the medical components of which shall be under the direction of a physician.

(2) Hospice care shall consist of a coordinated set of services rendered at home or in hospice residence or other institutional settings on a continuous basis for individuals suffering from a disease or condition with a terminal prognosis. The coordination of services shall assure that the transfer of a patient from 1 setting to another will be accomplished with a minimum disruption and discontinuity of care. Hospice services shall address the physical, psychological, social, and spiritual needs of the individual and shall be designed to meet the related needs of the individual's family through the periods of illness and bereavement. These hospice services shall be provided through a coordinated interdisciplinary team that may also include services provided by trained volunteers.

333.21417 Disease or condition with terminal prognosis as prerequisite for admission to or retention for care.

Sec. 21417.

An individual shall not be admitted to or retained for care by a hospice or a hospice residence unless the individual is suffering from a disease or condition with a terminal prognosis. An individual shall be considered to have a disease or condition with a

terminal prognosis if, in the opinion of a physician, the individual's death is anticipated within 6 months after the date of admission to the hospice or hospice residence. If a person lives beyond a 6-month or less prognosis, the person is not disqualified from receiving continued hospice care.