HOUSE SUBSTITUTE FOR

SENATE BILL NO. 957

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending section 20161 (MCL 333.20161), as amended by 2015 PA 104.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 20161. (1) The department shall assess fees and other
2 assessments for health facility and agency licenses and
3 certificates of need on an annual basis as provided in this
4 article. Until October 1, 2019, except as otherwise provided in
5 this article, fees and assessments shall be paid as provided in the
6 following schedule:

7 (a) Freestanding surgical
8 outpatient facilities................$500.00 per facility

1 license.
2 (b) Hospitals...................$500.00 per facility
3 license and $10.00 per
4 licensed bed.
5 (c) Nursing homes, county
6 medical care facilities, and
7 hospital long-term care units........$500.00 per facility
8 license and $3.00 per
9 licensed bed over 100
10 licensed beds.
11 (d) Homes for the aged..........$6.27 per licensed bed.
12 (e) Hospice agencies............$500.00 per agency license.
13 (f) Hospice residences..........$500.00 per facility
14 license and $5.00 per
15 licensed bed.
16 (g) Subject to subsection
17 (11), quality assurance assessment
18 for nursing homes and hospital
19 long-term care units................an amount resulting
20 in not more than 6%
21 of total industry
22 revenues.
23 (h) Subject to subsection
24 (12), quality assurance assessment
25 for hospitals.......................at a fixed or variable
26 rate that generates
27 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 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) 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.

1 (b) In addition to the fees under subdivision (a), the
2 applicant shall pay $3,000.00 for any designated complex project
3 including a project scheduled for comparative review or for a
4 consolidated licensed health facility application for acquisition
5 or replacement.
6 (c) If required by the department, the applicant shall pay
7 $1,000.00 for a certificate of need application that receives
8 expedited processing at the request of the applicant.
9 (d) The department shall charge a fee of $500.00 to review any
10 letter of intent requesting or resulting in a waiver from
11 certificate of need review and any amendment request to an approved
12 certificate of need.
13 (e) A health facility or agency that offers certificate of
14 need covered clinical services shall pay $100.00 for each
15 certificate of need approved covered clinical service as part of
16 the certificate of need annual survey at the time of submission of
17 the survey data.
18 (f) The department shall use the fees collected under this
19 subsection only to fund the certificate of need program. Funds
20 remaining in the certificate of need program at the end of the
21 fiscal year shall not lapse to the general fund but shall remain
22 available to fund the certificate of need program in subsequent
23 years.
24 (4) A license issued under this part is effective for no
25 longer than 1 year after the date of issuance.
26 (5) Fees described in this section are payable to the
27 department at the time an application for a license, permit, or

1 certificate is submitted. If an application for a license, permit,
2 or certificate is denied or if a license, permit, or certificate is
3 revoked before its expiration date, the department shall not refund
4 fees paid to the department.
5 (6) The fee for a provisional license or temporary permit is
6 the same as for a license. A license may be issued at the
7 expiration date of a temporary permit without an additional fee for
8 the balance of the period for which the fee was paid if the
9 requirements for licensure are met.
10 (7) The cost of licensure activities shall be supported by
11 license fees.
12 (8) The application fee for a waiver under section 21564 is
13 $200.00 plus $40.00 per hour for the professional services and
14 travel expenses directly related to processing the application. The
15 travel expenses shall be calculated in accordance with the state
16 standardized travel regulations of the department of technology,
17 management, and budget in effect at the time of the travel.
18 (9) An applicant for licensure or renewal of licensure under
19 part 209 shall pay the applicable fees set forth in part 209.
20 (10) Except as otherwise provided in this section, the fees
21 and assessments collected under this section shall be deposited in
22 the state treasury, to the credit of the general fund. The
23 department may use the unreserved fund balance in fees and
24 assessments for the criminal history check program required under
25 this article.
26 (11) The quality assurance assessment collected under
27 subsection (1)(g) and all federal matching funds attributed to that

1 assessment shall be used only for the following purposes and under
2 the following specific circumstances:
3 (a) The quality assurance assessment and all federal matching
4 funds attributed to that assessment shall be used to finance
5 Medicaid nursing home reimbursement payments. Only licensed nursing
6 homes and hospital long-term care units that are assessed the
7 quality assurance assessment and participate in the Medicaid
8 program are eligible for increased per diem Medicaid reimbursement
9 rates under this subdivision. A nursing home or long-term care unit
10 that is assessed the quality assurance assessment and that does not
11 pay the assessment required under subsection (1)(g) in accordance
12 with subdivision (c)(*i*) or in accordance with a written payment
13 agreement with ~~the~~ **THIS** state shall not receive the increased per
14 diem Medicaid reimbursement rates under this subdivision until all
15 of its outstanding quality assurance assessments and any penalties
16 assessed under subdivision (f) have been paid in full. This
17 subdivision does not authorize or require the department to
18 overspend tax revenue in violation of the management and budget
19 act, 1984 PA 431, MCL 18.1101 to 18.1594.
20 (b) Except as otherwise provided under subdivision (c),
21 beginning October 1, 2005, the quality assurance assessment is
22 based on the total number of patient days of care each nursing home
23 and hospital long-term care unit provided to non-Medicare patients
24 within the immediately preceding year**,** ~~and~~ shall be assessed at a
25 uniform rate on October 1, 2005 and subsequently on October 1 of
26 each following year, and is payable on a quarterly basis, **WITH** the
27 first payment due 90 days after the date the assessment is

1 assessed.

2 (c) Within 30 days after September 30, 2005, the department
3 shall submit an application to the federal Centers for Medicare and
4 Medicaid Services to request a waiver according to 42 CFR 433.68(e)
5 to implement this subdivision as follows:

6 (*i*) If the waiver is approved, the quality assurance
7 assessment rate for a nursing home or hospital long-term care unit
8 with less than 40 licensed beds or with the maximum number, or more
9 than the maximum number, of licensed beds necessary to secure
10 federal approval of the application is $2.00 per non-Medicare
11 patient day of care provided within the immediately preceding year
12 or a rate as otherwise altered on the application for the waiver to
13 obtain federal approval. If the waiver is approved, for all other
14 nursing homes and long-term care units the quality assurance
15 assessment rate is to be calculated by dividing the total statewide
16 maximum allowable assessment permitted under subsection (1)(g) less
17 the total amount to be paid by the nursing homes and long-term care
18 units with less than 40 **LICENSED BEDS** or with the maximum number,
19 or more than the maximum number, of licensed beds necessary to
20 secure federal approval of the application by the total number of
21 non-Medicare patient days of care provided within the immediately
22 preceding year by those nursing homes and long-term care units with
23 more than 39 **LICENSED BEDS**, but less than the maximum number of
24 licensed beds necessary to secure federal approval. The quality
25 assurance assessment, as provided under this subparagraph, shall be
26 assessed in the first quarter after federal approval of the waiver
27 and shall be subsequently assessed on October 1 of each following

1 year, and is payable on a quarterly basis, the first payment due 90
2 days after the date the assessment is assessed.
3 (*ii*) If the waiver is approved, continuing care retirement
4 centers are exempt from the quality assurance assessment if the
5 continuing care retirement center requires each center resident to
6 provide an initial life interest payment of $150,000.00, on
7 average, per resident to ensure payment for that resident's
8 residency and services and the continuing care retirement center
9 utilizes all of the initial life interest payment before the
10 resident becomes eligible for medical assistance under the state's
11 Medicaid plan. As used in this subparagraph, "continuing care
12 retirement center" means a nursing care facility that provides
13 independent living services, assisted living services, and nursing
14 care and medical treatment services, in a campus-like setting that
15 has shared facilities or common areas, or both.
16 (d) Beginning May 10, 2002, the department shall increase the
17 per diem nursing home Medicaid reimbursement rates for the balance
18 of that year. For each subsequent year in which the quality
19 assurance assessment is assessed and collected, the department
20 shall maintain the Medicaid nursing home reimbursement payment
21 increase financed by the quality assurance assessment.
22 (e) The department shall implement this section in a manner
23 that complies with federal requirements necessary to ensure that
24 the quality assurance assessment qualifies for federal matching
25 funds.
26 (f) If a nursing home or a hospital long-term care unit fails
27 to pay the assessment required by subsection (1)(g), the department

1 may assess the nursing home or hospital long-term care unit a
2 penalty of 5% of the assessment for each month that the assessment
3 and penalty are not paid up to a maximum of 50% of the assessment.
4 The department may also refer for collection to the department of
5 treasury past due amounts consistent with section 13 of 1941 PA
6 122, MCL 205.13.
7 (g) The Medicaid nursing home quality assurance assessment
8 fund is established in the state treasury. The department shall
9 deposit the revenue raised through the quality assurance assessment
10 with the state treasurer for deposit in the Medicaid nursing home
11 quality assurance assessment fund.
12 (h) The department shall not implement this subsection in a
13 manner that conflicts with 42 USC 1396b(w).
14 (i) The quality assurance assessment collected under
15 subsection (1)(g) shall be prorated on a quarterly basis for any
16 licensed beds added to or subtracted from a nursing home or
17 hospital long-term care unit since the immediately preceding July
18 1. Any adjustments in payments are due on the next quarterly
19 installment due date.
20 (j) In each fiscal year governed by this subsection, Medicaid
21 reimbursement rates shall not be reduced below the Medicaid
22 reimbursement rates in effect on April 1, 2002 as a direct result
23 of the quality assurance assessment collected under subsection
24 (1)(g).
25 (k) The state retention amount of the quality assurance
26 assessment collected under subsection (1)(g) shall be equal to
27 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 shall be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds shall offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2019, the department shall ~~no longer~~ **NOT** assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection (1)(g) shall ~~no longer~~ **NOT** be assessed or collected after September 30, 2011 ~~, in the event that~~ **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 shall 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 shall 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 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, **WITH** the first

1 payment due 90 days after the date the assessment is assessed. As
2 used in this subdivision, "Medicare net revenue" includes Medicare
3 payments and amounts collected for coinsurance and deductibles.
4 (c) Beginning October 1, 2002, the department shall increase
5 the hospital Medicaid reimbursement rates for the balance of that
6 year. For each subsequent year in which the quality assurance
7 assessment is assessed and collected, the department shall maintain
8 the hospital Medicaid reimbursement rate increase financed by the
9 quality assurance assessments.
10 (d) The department shall implement this section in a manner
11 that complies with federal requirements necessary to ensure that
12 the quality assurance assessment qualifies for federal matching
13 funds.
14 (e) If a hospital fails to pay the assessment required by
15 subsection (1)(h), the department may assess the hospital a penalty
16 of 5% of the assessment for each month that the assessment and
17 penalty are not paid up to a maximum of 50% of the assessment. The
18 department may also refer for collection to the department of
19 treasury past due amounts consistent with section 13 of 1941 PA
20 122, MCL 205.13.
21 (f) The hospital quality assurance assessment fund is
22 established in the state treasury. The department shall deposit the
23 revenue raised through the quality assurance assessment with the
24 state treasurer for deposit in the hospital quality assurance
25 assessment fund.
26 (g) In each fiscal year governed by this subsection, the
27 quality assurance assessment shall only be collected and expended

1 if Medicaid hospital inpatient DRG and outpatient reimbursement
2 rates and disproportionate share hospital and graduate medical
3 education payments are not below the level of rates and payments in
4 effect on April 1, 2002 as a direct result of the quality assurance
5 assessment collected under subsection (1)(h), except as provided in
6 subdivision (h).
7 (h) The quality assurance assessment collected under
8 subsection (1)(h) shall ~~no longer~~ **NOT** be assessed or collected
9 after September 30, 2011 ~~in the event that~~ **IF** the quality assurance
10 assessment is not eligible for federal matching funds. Any portion
11 of the quality assurance assessment collected from a hospital that
12 is not eligible for federal matching funds shall be returned to the
13 hospital.
14 (i) The state retention amount of the quality assurance
15 assessment collected under subsection (1)(h) shall be equal to
16 13.2% of the federal funds generated by the hospital quality
17 assurance assessment, including the state retention amount. **THE**
18 **13.2% STATE RETENTION AMOUNT DESCRIBED IN THIS SUBDIVISION DOES NOT**
19 **APPLY TO THE HEALTHY MICHIGAN PLAN.** In the fiscal year ending
20 September 30, 2016, there is a 1-time additional retention amount
21 of up to $92,856,100.00. **BEGINNING IN THE FISCAL YEAR ENDING**
22 **SEPTEMBER 30, 2017, AND FOR EACH FISCAL YEAR THEREAFTER, THERE IS A**
23 **RETENTION AMOUNT OF $105,000,000.00 FOR EACH FISCAL YEAR FOR THE**
24 **HEALTHY MICHIGAN PLAN.** The state retention percentage shall be
25 applied proportionately to each hospital quality assurance
26 assessment program to determine the retention amount for each
27 program. The state retention amount shall be appropriated each

1 fiscal year to the department to support Medicaid expenditures for
2 hospital services and therapy. These funds shall offset an
3 identical amount of general fund/general purpose revenue originally
4 appropriated for that purpose. **BY MAY 31, 2019, THE DEPARTMENT, THE**
5 **STATE BUDGET OFFICE, AND THE MICHIGAN HEALTH AND HOSPITAL**
6 **ASSOCIATION SHALL IDENTIFY AN APPROPRIATE RETENTION AMOUNT FOR THE**
7 **FISCAL YEAR ENDING SEPTEMBER 30, 2020 AND EACH FISCAL YEAR**
8 **THEREAFTER.**
9 (13) The department may establish a quality assurance
10 assessment to increase ambulance reimbursement as follows:
11 (a) The quality assurance assessment authorized under this
12 subsection shall be used to provide reimbursement to Medicaid
13 ambulance providers. The department may promulgate rules to provide
14 the structure of the quality assurance assessment authorized under
15 this subsection and the level of the assessment.
16 (b) The department shall implement this subsection in a manner
17 that complies with federal requirements necessary to ensure that
18 the quality assurance assessment qualifies for federal matching
19 funds.
20 (c) The total annual collections by the department under this
21 subsection shall not exceed $20,000,000.00.
22 (d) The quality assurance assessment authorized under this
23 subsection shall not be collected after October 1, 2019. The
24 quality assurance assessment authorized under this subsection shall
25 no longer be collected or assessed if the quality assurance
26 assessment authorized under this subsection is not eligible for
27 federal matching funds.

1 (14) The quality assurance assessment provided for under this
2 section is a tax that is levied on a health facility or agency.
3 (15) As used in this section: ,
4 **(A) "HEALTHY MICHIGAN PLAN" MEANS THE MEDICAL ASSISTANCE PLAN**
5 **DESCRIBED IN SECTION 105D OF THE SOCIAL WELFARE ACT, 1939 PA 280,**
6 **MCL 400.105D.**
7 **(B)** "Medicaid" means that term as defined in section 22207.