

1 license and \$10.00 per
2 licensed bed.

3 (c) Nursing homes, county
4 medical care facilities, and
5 hospital long-term care units.....\$500.00 per facility
6 license and \$3.00 per
7 licensed bed over 100
8 licensed beds.

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

10 (e) Hospice agencies.....\$500.00 per agency license.

11 (f) Hospice residences.....\$500.00 per facility
12 license and \$5.00 per
13 licensed bed.

14 (g) Subject to subsection
15 (11), quality assurance assessment
16 for nursing homes and hospital
17 long-term care units.....an amount resulting
18 in not more than 6%
19 of total industry
20 revenues.

21 (h) Subject to subsection
22 (12), quality assurance assessment
23 for hospitals.....at a fixed or variable
24 rate that generates
25 funds not more than the
26 maximum allowable under
27 the federal matching

1 requirements, after
2 consideration for the
3 amounts in subsection
4 (12)(a) and (i).

5 (i) Initial licensure
6 application fee for subdivisions
7 (a), (b), (c), (e), and (f).....\$2,000.00 per initial
8 license.

9 (2) If a hospital requests the department to conduct a
10 certification survey for purposes of title XVIII or title XIX of
11 the social security act, the hospital shall pay a license fee
12 surcharge of \$23.00 per bed. As used in this subsection, "title
13 XVIII" and "title XIX" mean those terms as defined in section
14 20155.

15 (3) All of the following apply to the assessment under this
16 section for certificates of need:

17 (a) The base fee for a certificate of need is \$3,000.00 for
18 each application. For a project requiring a projected capital
19 expenditure of more than \$500,000.00 but less than \$4,000,000.00,
20 an additional fee of \$5,000.00 is added to the base fee. For a
21 project requiring a projected capital expenditure of \$4,000,000.00
22 or more but less than \$10,000,000.00, an additional fee of
23 \$8,000.00 is added to the base fee. For a project requiring a
24 projected capital expenditure of \$10,000,000.00 or more, an
25 additional fee of \$12,000.00 is added to the base fee.

26 (b) In addition to the fees under subdivision (a), the
27 applicant shall pay \$3,000.00 for any designated complex project

1 including a project scheduled for comparative review or for a
2 consolidated licensed health facility application for acquisition
3 or replacement.

4 (c) If required by the department, the applicant shall pay
5 \$1,000.00 for a certificate of need application that receives
6 expedited processing at the request of the applicant.

7 (d) The department shall charge a fee of \$500.00 to review any
8 letter of intent requesting or resulting in a waiver from
9 certificate of need review and any amendment request to an approved
10 certificate of need.

11 (e) A health facility or agency that offers certificate of
12 need covered clinical services shall pay \$100.00 for each
13 certificate of need approved covered clinical service as part of
14 the certificate of need annual survey at the time of submission of
15 the survey data.

16 (f) The department shall use the fees collected under this
17 subsection only to fund the certificate of need program. Funds
18 remaining in the certificate of need program at the end of the
19 fiscal year shall not lapse to the general fund but shall remain
20 available to fund the certificate of need program in subsequent
21 years.

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

24 (5) Fees described in this section are payable to the
25 department at the time an application for a license, permit, or
26 certificate is submitted. If an application for a license, permit,
27 or certificate is denied or if a license, permit, or certificate is

1 revoked before its expiration date, the department shall not refund
2 fees paid to the department.

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

8 (7) The cost of licensure activities shall be supported by
9 license fees.

10 (8) The application fee for a waiver under section 21564 is
11 \$200.00 plus \$40.00 per hour for the professional services and
12 travel expenses directly related to processing the application. The
13 travel expenses shall be calculated in accordance with the state
14 standardized travel regulations of the department of technology,
15 management, and budget in effect at the time of the travel.

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

18 (10) Except as otherwise provided in this section, the fees
19 and assessments collected under this section shall be deposited in
20 the state treasury, to the credit of the general fund. The
21 department may use the unreserved fund balance in fees and
22 assessments for the criminal history check program required under
23 this article.

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

1 (a) The quality assurance assessment and all federal matching
2 funds attributed to that assessment shall be used to finance
3 Medicaid nursing home reimbursement payments. Only licensed nursing
4 homes and hospital long-term care units that are assessed the
5 quality assurance assessment and participate in the Medicaid
6 program are eligible for increased per diem Medicaid reimbursement
7 rates under this subdivision. A nursing home or long-term care unit
8 that is assessed the quality assurance assessment and that does not
9 pay the assessment required under subsection (1)(g) in accordance
10 with subdivision (c)(i) or in accordance with a written payment
11 agreement with ~~the~~**THIS** state shall not receive the increased per
12 diem Medicaid reimbursement rates under this subdivision until all
13 of its outstanding quality assurance assessments and any penalties
14 assessed under subdivision (f) have been paid in full. This
15 subdivision does not authorize or require the department to
16 overspend tax revenue in violation of the management and budget
17 act, 1984 PA 431, MCL 18.1101 to 18.1594.

18 (b) Except as otherwise provided under subdivision (c),
19 beginning October 1, 2005, the quality assurance assessment is
20 based on the total number of patient days of care each nursing home
21 and hospital long-term care unit provided to non-Medicare patients
22 within the immediately preceding year, ~~and~~ shall be assessed at a
23 uniform rate on October 1, 2005 and subsequently on October 1 of
24 each following year, and is payable on a quarterly basis, **WITH** the
25 first payment due 90 days after the date the assessment is
26 assessed.

27 (c) Within 30 days after September 30, 2005, the department

1 shall submit an application to the federal Centers for Medicare and
2 Medicaid Services to request a waiver according to 42 CFR 433.68(e)
3 to implement this subdivision as follows:

4 (i) If the waiver is approved, the quality assurance
5 assessment rate for a nursing home or hospital long-term care unit
6 with less than 40 licensed beds or with the maximum number, or more
7 than the maximum number, of licensed beds necessary to secure
8 federal approval of the application is \$2.00 per non-Medicare
9 patient day of care provided within the immediately preceding year
10 or a rate as otherwise altered on the application for the waiver to
11 obtain federal approval. If the waiver is approved, for all other
12 nursing homes and long-term care units the quality assurance
13 assessment rate is to be calculated by dividing the total statewide
14 maximum allowable assessment permitted under subsection (1)(g) less
15 the total amount to be paid by the nursing homes and long-term care
16 units with less than 40 **LICENSED BEDS** or with the maximum number,
17 or more than the maximum number, of licensed beds necessary to
18 secure federal approval of the application by the total number of
19 non-Medicare patient days of care provided within the immediately
20 preceding year by those nursing homes and long-term care units with
21 more than 39 **LICENSED BEDS**, but less than the maximum number of
22 licensed beds necessary to secure federal approval. The quality
23 assurance assessment, as provided under this subparagraph, shall be
24 assessed in the first quarter after federal approval of the waiver
25 and shall be subsequently assessed on October 1 of each following
26 year, and is payable on a quarterly basis, the first payment due 90
27 days after the date the assessment is assessed.

1 (ii) If the waiver is approved, continuing care retirement
2 centers are exempt from the quality assurance assessment if the
3 continuing care retirement center requires each center resident to
4 provide an initial life interest payment of \$150,000.00, on
5 average, per resident to ensure payment for that resident's
6 residency and services and the continuing care retirement center
7 utilizes all of the initial life interest payment before the
8 resident becomes eligible for medical assistance under the state's
9 Medicaid plan. As used in this subparagraph, "continuing care
10 retirement center" means a nursing care facility that provides
11 independent living services, assisted living services, and nursing
12 care and medical treatment services, in a campus-like setting that
13 has shared facilities or common areas, or both.

14 (d) Beginning May 10, 2002, the department shall increase the
15 per diem nursing home Medicaid reimbursement rates for the balance
16 of that year. For each subsequent year in which the quality
17 assurance assessment is assessed and collected, the department
18 shall maintain the Medicaid nursing home reimbursement payment
19 increase financed by the quality assurance assessment.

20 (e) The department shall implement this section in a manner
21 that complies with federal requirements necessary to ensure that
22 the quality assurance assessment qualifies for federal matching
23 funds.

24 (f) If a nursing home or a hospital long-term care unit fails
25 to pay the assessment required by subsection (1)(g), the department
26 may assess the nursing home or hospital long-term care unit a
27 penalty of 5% of the assessment for each month that the assessment

1 and penalty are not paid up to a maximum of 50% of the assessment.
2 The department may also refer for collection to the department of
3 treasury past due amounts consistent with section 13 of 1941 PA
4 122, MCL 205.13.

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

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

12 (i) The quality assurance assessment collected under
13 subsection (1)(g) shall be prorated on a quarterly basis for any
14 licensed beds added to or subtracted from a nursing home or
15 hospital long-term care unit since the immediately preceding July
16 1. Any adjustments in payments are due on the next quarterly
17 installment due date.

18 (j) In each fiscal year governed by this subsection, Medicaid
19 reimbursement rates shall not be reduced below the Medicaid
20 reimbursement rates in effect on April 1, 2002 as a direct result
21 of the quality assurance assessment collected under subsection
22 (1)(g).

23 (k) The state retention amount of the quality assurance
24 assessment collected under subsection (1)(g) shall be equal to
25 13.2% of the federal funds generated by the nursing homes and
26 hospital long-term care units quality assurance assessment,
27 including the state retention amount. The state retention amount

1 shall be appropriated each fiscal year to the department to support
2 Medicaid expenditures for long-term care services. These funds
3 shall offset an identical amount of general fund/general purpose
4 revenue originally appropriated for that purpose.

5 (l) Beginning October 1, 2019, the department shall ~~no longer~~
6 **NOT** assess or collect the quality assurance assessment or apply for
7 federal matching funds. The quality assurance assessment collected
8 under subsection (1)(g) shall ~~no longer~~ **NOT** be assessed or
9 collected after September 30, 2011, ~~in the event that~~ **IF** the
10 quality assurance assessment is not eligible for federal matching
11 funds. Any portion of the quality assurance assessment collected
12 from a nursing home or hospital long-term care unit that is not
13 eligible for federal matching funds shall be returned to the
14 nursing home or hospital long-term care unit.

15 (12) The quality assurance dedication is an earmarked
16 assessment collected under subsection (1)(h). That assessment and
17 all federal matching funds attributed to that assessment shall be
18 used only for the following purpose and under the following
19 specific circumstances:

20 (a) To maintain the increased Medicaid reimbursement rate
21 increases as provided for in subdivision (c).

22 (b) The quality assurance assessment shall be assessed on all
23 net patient revenue, before deduction of expenses, less Medicare
24 net revenue, as reported in the most recently available Medicare
25 cost report and is payable on a quarterly basis, the first payment
26 due 90 days after the date the assessment is assessed. As used in
27 this subdivision, "Medicare net revenue" includes Medicare payments

1 and amounts collected for coinsurance and deductibles.

2 (c) Beginning October 1, 2002, the department shall increase
3 the hospital Medicaid reimbursement rates for the balance of that
4 year. For each subsequent year in which the quality assurance
5 assessment is assessed and collected, the department shall maintain
6 the hospital Medicaid reimbursement rate increase financed by the
7 quality assurance assessments.

8 (d) The department shall implement this section in a manner
9 that complies with federal requirements necessary to ensure that
10 the quality assurance assessment qualifies for federal matching
11 funds.

12 (e) If a hospital fails to pay the assessment required by
13 subsection (1)(h), the department may assess the hospital a penalty
14 of 5% of the assessment for each month that the assessment and
15 penalty are not paid up to a maximum of 50% of the assessment. The
16 department may also refer for collection to the department of
17 treasury past due amounts consistent with section 13 of 1941 PA
18 122, MCL 205.13.

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

24 (g) In each fiscal year governed by this subsection, the
25 quality assurance assessment shall only be collected and expended
26 if Medicaid hospital inpatient DRG and outpatient reimbursement
27 rates and disproportionate share hospital and graduate medical

1 education payments are not below the level of rates and payments in
2 effect on April 1, 2002 as a direct result of the quality assurance
3 assessment collected under subsection (1)(h), except as provided in
4 subdivision (h).

5 (h) The quality assurance assessment collected under
6 subsection (1)(h) shall ~~no longer~~ **NOT** be assessed or collected
7 after September 30, 2011 ~~in the event that~~ **IF** the quality assurance
8 assessment is not eligible for federal matching funds. Any portion
9 of the quality assurance assessment collected from a hospital that
10 is not eligible for federal matching funds shall be returned to the
11 hospital.

12 (i) The state retention amount of the quality assurance
13 assessment collected under subsection (1)(h) shall be equal to
14 13.2% of the federal funds generated by the hospital quality
15 assurance assessment, including the state retention amount. In the
16 fiscal year ending September 30, 2016, there is a 1-time additional
17 retention amount of up to \$92,856,100.00. **BEGINNING IN THE FISCAL**
18 **YEAR ENDING SEPTEMBER 30, 2017, AND FOR EACH FISCAL YEAR**
19 **THEREAFTER, THERE IS AN ADDITIONAL RETENTION AMOUNT OF**
20 **\$105,000,000.00 FOR EACH FISCAL YEAR.** The state retention
21 percentage shall be applied proportionately to each hospital
22 quality assurance assessment program to determine the retention
23 amount for each program. The state retention amount shall be
24 appropriated each fiscal year to the department to support Medicaid
25 expenditures for hospital services and therapy. These funds shall
26 offset an identical amount of general fund/general purpose revenue
27 originally appropriated for that purpose. **BY MAY 31, 2019, THE**

1 DEPARTMENT, THE STATE BUDGET OFFICE, AND THE MICHIGAN HEALTH AND
2 HOSPITAL ASSOCIATION SHALL IDENTIFY AN APPROPRIATE RETENTION AMOUNT
3 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2020 AND EACH FISCAL YEAR
4 THEREAFTER.

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

7 (a) The quality assurance assessment authorized under this
8 subsection shall be used to provide reimbursement to Medicaid
9 ambulance providers. The department may promulgate rules to provide
10 the structure of the quality assurance assessment authorized under
11 this subsection and the level of the assessment.

12 (b) The department shall implement this subsection in a manner
13 that complies with federal requirements necessary to ensure that
14 the quality assurance assessment qualifies for federal matching
15 funds.

16 (c) The total annual collections by the department under this
17 subsection shall not exceed \$20,000,000.00.

18 (d) The quality assurance assessment authorized under this
19 subsection shall not be collected after October 1, 2019. The
20 quality assurance assessment authorized under this subsection shall
21 no longer be collected or assessed if the quality assurance
22 assessment authorized under this subsection is not eligible for
23 federal matching funds.

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

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