



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~~**DO** 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~~**MUST** be supported  
9 by 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~~**MUST** be calculated in accordance with the  
14 state standardized travel regulations of the department of  
15 technology, management, and budget in effect at the time of the  
16 travel.

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

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

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

1 under the following specific circumstances:

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

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

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

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

1 payment due 90 days after the date the assessment is assessed.

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

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

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

25 (f) If a nursing home or a hospital long-term care unit fails  
26 to pay the assessment required by subsection (1)(g), the department  
27 may assess the nursing home or hospital long-term care unit a

1 penalty of 5% of the assessment for each month that the assessment  
2 and penalty are not paid up to a maximum of 50% of the assessment.  
3 The department may also refer for collection to the department of  
4 treasury past due amounts consistent with section 13 of 1941 PA  
5 122, MCL 205.13.

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

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

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

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

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

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

6 (l) Beginning October 1, 2019, the department shall not assess  
7 or collect the quality assurance assessment or apply for federal  
8 matching funds. The quality assurance assessment collected under  
9 subsection (1)(g) ~~shall~~**MUST** not be assessed or collected after  
10 September 30, 2011 if the quality assurance assessment is not  
11 eligible for federal matching funds. Any portion of the quality  
12 assurance assessment collected from a nursing home or hospital  
13 long-term care unit that is not eligible for federal matching funds  
14 ~~shall~~**MUST** be returned to the nursing home or hospital long-term  
15 care unit.

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

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

23 (b) The quality assurance assessment ~~shall~~**MUST** be assessed on  
24 all net patient revenue, before deduction of expenses, less  
25 Medicare net revenue, as reported in the most recently available  
26 Medicare cost report and is payable on a quarterly basis, with the  
27 first payment due 90 days after the date the assessment is

1 assessed. As used in this subdivision, "Medicare net revenue"  
2 includes Medicare payments and amounts collected for coinsurance  
3 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~~**MUST** only be collected and

1 expended if Medicaid hospital inpatient DRG and outpatient  
2 reimbursement rates and disproportionate share hospital and  
3 graduate medical education payments are not below the level of  
4 rates and payments in effect on April 1, 2002 as a direct result of  
5 the quality assurance assessment collected under subsection (1)(h),  
6 except as provided in subdivision (h).

7 (h) The quality assurance assessment collected under  
8 subsection (1)(h) ~~shall~~**MUST** not be assessed or collected after  
9 September 30, 2011 if the quality assurance assessment is not  
10 eligible for federal matching funds. Any portion of the quality  
11 assurance assessment collected from a hospital that is not eligible  
12 for federal matching funds ~~shall~~**MUST** be returned to the hospital.

13 (i) The state retention amount of the quality assurance  
14 assessment collected under subsection (1)(h) ~~shall~~**MUST** be equal to  
15 13.2% of the federal funds generated by the hospital quality  
16 assurance assessment, including the state retention amount. The  
17 13.2% state retention amount described in this subdivision does not  
18 apply to the Healthy Michigan plan. In the fiscal year ending  
19 September 30, 2016, there is a 1-time additional retention amount  
20 of up to \$92,856,100.00. ~~Beginning in~~**IN** the fiscal year ending  
21 September 30, 2017, ~~and for each fiscal year thereafter,~~ there is a  
22 retention amount of \$105,000,000.00 ~~for each fiscal year~~ for the  
23 Healthy Michigan plan. **BEGINNING IN THE FISCAL YEAR ENDING**  
24 **SEPTEMBER 30, 2018, AND FOR EACH FISCAL YEAR THEREAFTER, THERE IS A**  
25 **RETENTION AMOUNT OF \$118,420,600.00 FOR EACH FISCAL YEAR FOR THE**  
26 **HEALTHY MICHIGAN PLAN.** The state retention percentage ~~shall~~**MUST** be  
27 applied proportionately to each hospital quality assurance

1 assessment program to determine the retention amount for each  
2 program. The state retention amount ~~shall~~**MUST** be appropriated each  
3 fiscal year to the department to support Medicaid expenditures for  
4 hospital services and therapy. These funds ~~shall~~**MUST** offset an  
5 identical amount of general fund/general purpose revenue originally  
6 appropriated for that purpose. By May 31, 2019, the department, the  
7 state budget office, and the Michigan Health and Hospital  
8 Association shall identify an appropriate retention amount for the  
9 fiscal year ending September 30, 2020 and each fiscal year  
10 thereafter.

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

13 (a) The quality assurance assessment authorized under this  
14 subsection ~~shall~~**MUST** be used to provide reimbursement to Medicaid  
15 ambulance providers. The department may promulgate rules to provide  
16 the structure of the quality assurance assessment authorized under  
17 this subsection and the level of the assessment.

18 (b) The department shall implement this subsection in a manner  
19 that complies with federal requirements necessary to ensure that  
20 the quality assurance assessment qualifies for federal matching  
21 funds.

22 (c) The total annual collections by the department under this  
23 subsection ~~shall~~**MUST** not exceed \$20,000,000.00.

24 (d) The quality assurance assessment authorized under this  
25 subsection ~~shall~~**MUST** not be collected after October 1, 2019. The  
26 quality assurance assessment authorized under this subsection ~~shall~~  
27 **MUST** no longer be collected or assessed if the quality assurance

1 assessment authorized under this subsection is not eligible for  
2 federal matching funds.

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

5 (15) As used in this section:

6 (a) "Healthy Michigan plan" means the medical assistance ~~plan~~  
7 **PROGRAM** described in section 105d of the social welfare act, 1939  
8 PA 280, MCL 400.105d, that has a federal matching fund rate of not  
9 less than 90%.

10 (b) "Medicaid" means that term as defined in section 22207.