

HOUSE BILL NO. 6176

September 03, 2020, Introduced by Reps. Allor, Crawford, Rendon, O'Malley, Bellino, Steven Johnson, Reilly, Miller and Whiteford and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled
"Public health code,"
by amending section 20161 (MCL 333.20161), as amended by 2020 PA
35.

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, 2023, except as otherwise provided in



1 this article, fees and assessments must be paid as provided in the
 2 following schedule:

3 (a) Freestanding surgical
 4 outpatient facilities.....\$500.00 per facility license.

5 (b) Hospitals \$500.00 per facility license and
 6 \$10.00 per licensed bed.

7 (c) Nursing homes, county
 8 medical care facilities, and
 9 hospital long-term care units\$500.00 per facility license and
 10 \$3.00 per licensed bed over 100
 11 licensed beds.

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

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

14 (f) Hospice residences \$500.00 per facility license and
 15 \$5.00 per licensed bed.

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

22 (h) Subject to subsection
 23 (12), quality assurance assessment
 24 for hospitalsat a fixed or variable rate that



generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i).

(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, 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.

(b) In addition to the fees under subdivision (a), the applicant shall pay \$3,000.00 for any designated complex project including a project scheduled for comparative review or for a consolidated licensed health facility application for acquisition



1 or replacement.

2 (c) If required by the department, the applicant shall pay
3 \$1,000.00 for a certificate of need application that receives
4 expedited processing at the request of the applicant.

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

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

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

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

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

27 (6) The fee for a provisional license or temporary permit is
28 the same as for a license. A license may be issued at the
29 expiration date of a temporary permit without an additional fee for



1 the balance of the period for which the fee was paid if the
2 requirements for licensure are met.

3 (7) The cost of licensure activities must be supported by
4 license fees.

5 (8) The application fee for a waiver under section 21564 is
6 \$200.00 plus \$40.00 per hour for the professional services and
7 travel expenses directly related to processing the application. The
8 travel expenses must be calculated in accordance with the state
9 standardized travel regulations of the department of technology,
10 management, and budget in effect at the time of the travel.

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

13 (10) Except as otherwise provided in this section, the fees
14 and assessments collected under this section must be deposited in
15 the state treasury, to the credit of the general fund. The
16 department may use the unreserved fund balance in fees and
17 assessments for the criminal history check program required under
18 this article.

19 (11) The quality assurance assessment collected under
20 subsection (1)(g) and all federal matching funds attributed to that
21 assessment must be used only for the following purposes and under
22 the following specific circumstances:

23 (a) The quality assurance assessment and all federal matching
24 funds attributed to that assessment must be used to finance
25 Medicaid nursing home reimbursement payments. Only licensed nursing
26 homes and hospital long-term care units that are assessed the
27 quality assurance assessment and participate in the Medicaid
28 program are eligible for increased per diem Medicaid reimbursement
29 rates under this subdivision. A nursing home or long-term care unit



1 that is assessed the quality assurance assessment and that does not
2 pay the assessment required under subsection (1)(g) in accordance
3 with subdivision (c)(i) or in accordance with a written payment
4 agreement with this state shall not receive the increased per diem
5 Medicaid reimbursement rates under this subdivision until all of
6 its outstanding quality assurance assessments and any penalties
7 assessed under subdivision (f) have been paid in full. This
8 subdivision does not authorize or require the department to
9 overspend tax revenue in violation of the management and budget
10 act, 1984 PA 431, MCL 18.1101 to 18.1594.

11 (b) Except as otherwise provided under subdivision (c),
12 beginning October 1, 2005, the quality assurance assessment is
13 based on the total number of patient days of care each nursing home
14 and hospital long-term care unit provided to non-Medicare patients
15 within the immediately preceding year, must be assessed at a
16 uniform rate on October 1, 2005 and subsequently on October 1 of
17 each following year, and is payable on a quarterly basis, with the
18 first payment due 90 days after the date the assessment is
19 assessed.

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

24 (i) If the waiver is approved, the quality assurance assessment
25 rate for a nursing home or hospital long-term care unit with less
26 than 40 licensed beds or with the maximum number, or more than the
27 maximum number, of licensed beds necessary to secure federal
28 approval of the application is \$2.00 per non-Medicare patient day
29 of care provided within the immediately preceding year or a rate as



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

19 (ii) If the waiver is approved, continuing care retirement
20 centers are exempt from the quality assurance assessment if the
21 continuing care retirement center requires each center resident to
22 provide an initial life interest payment of \$150,000.00, on
23 average, per resident to ensure payment for that resident's
24 residency and services and the continuing care retirement center
25 utilizes all of the initial life interest payment before the
26 resident becomes eligible for medical assistance under the state's
27 Medicaid plan. As used in this subparagraph, "continuing care
28 retirement center" means a nursing care facility that provides
29 independent living services, assisted living services, and nursing



1 care and medical treatment services, in a campus-like setting that
2 has shared facilities or common areas, or both.

3 (d) Beginning May 10, 2002, the department shall increase the
4 per diem nursing home Medicaid reimbursement rates for the balance
5 of that year. For each subsequent year in which the quality
6 assurance assessment is assessed and collected, the department
7 shall maintain the Medicaid nursing home reimbursement payment
8 increase financed by the quality assurance assessment.

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

13 (f) If a nursing home or a hospital long-term care unit fails
14 to pay the assessment required by subsection (1)(g), the department
15 may assess the nursing home or hospital long-term care unit a
16 penalty of 5% of the assessment for each month that the assessment
17 and penalty are not paid up to a maximum of 50% of the assessment.
18 The 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 (g) The Medicaid nursing home quality assurance assessment
22 fund is established in the state treasury. The department shall
23 deposit the revenue raised through the quality assurance assessment
24 with the state treasurer for deposit in the Medicaid nursing home
25 quality assurance assessment fund.

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

28 (i) The quality assurance assessment collected under
29 subsection (1)(g) must be prorated on a quarterly basis for any



1 licensed beds added to or subtracted from a nursing home or
2 hospital long-term care unit since the immediately preceding July
3 1. Any adjustments in payments are due on the next quarterly
4 installment due date.

5 (j) In each fiscal year governed by this subsection, Medicaid
6 reimbursement rates must not be reduced below the Medicaid
7 reimbursement rates in effect on April 1, 2002 as a direct result
8 of the quality assurance assessment collected under subsection
9 (1)(g).

10 (k) The state retention amount of the quality assurance
11 assessment collected under subsection (1)(g) must be equal to 13.2%
12 of the federal funds generated by the nursing homes and hospital
13 long-term care units quality assurance assessment, including the
14 state retention amount. The state retention amount must be
15 appropriated each fiscal year to the department to support Medicaid
16 expenditures for long-term care services. These funds must offset
17 an identical amount of general fund/general purpose revenue
18 originally appropriated for that purpose.

19 (l) Beginning October 1, 2023, the department shall not assess
20 or collect the quality assurance assessment or apply for federal
21 matching funds. The quality assurance assessment collected under
22 subsection (1)(g) must not be assessed or collected after September
23 30, 2011 if the quality assurance assessment is not eligible for
24 federal matching funds. Any portion of the quality assurance
25 assessment collected from a nursing home or hospital long-term care
26 unit that is not eligible for federal matching funds must be
27 returned to the nursing home or hospital long-term care unit.

28 (12) The quality assurance dedication is an earmarked
29 assessment collected under subsection (1)(h). That assessment and



1 all federal matching funds attributed to that assessment must be
2 used only for the following purpose and under the following
3 specific circumstances:

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

6 (b) The quality assurance assessment must be assessed on all
7 net patient revenue, before deduction of expenses, less Medicare
8 net revenue, as reported in the most recently available Medicare
9 cost report and is payable on a quarterly basis, with the first
10 payment due 90 days after the date the assessment is assessed. As
11 used in this subdivision, "Medicare net revenue" includes Medicare
12 payments and amounts collected for coinsurance and deductibles.

13 (c) Beginning October 1, 2002, the department shall increase
14 the hospital Medicaid reimbursement rates for the balance of that
15 year. For each subsequent year in which the quality assurance
16 assessment is assessed and collected, the department shall maintain
17 the hospital Medicaid reimbursement rate increase financed by the
18 quality assurance assessments.

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

23 (e) If a hospital fails to pay the assessment required by
24 subsection (1)(h), the department may assess the hospital a penalty
25 of 5% of the assessment for each month that the assessment and
26 penalty are not paid up to a maximum of 50% of the assessment. The
27 department may also refer for collection to the department of
28 treasury past due amounts consistent with section 13 of 1941 PA
29 122, MCL 205.13.



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

6 (g) In each fiscal year governed by this subsection, the
7 quality assurance assessment must only be collected and expended if
8 Medicaid hospital inpatient DRG and outpatient reimbursement rates
9 and disproportionate share hospital and graduate medical education
10 payments are not below the level of rates and payments in effect on
11 April 1, 2002 as a direct result of the quality assurance
12 assessment collected under subsection (1)(h), except as provided in
13 subdivision (h).

14 (h) The quality assurance assessment collected under
15 subsection (1)(h) must not be assessed or collected after September
16 30, 2011 if the quality assurance assessment is not eligible for
17 federal matching funds. Any portion of the quality assurance
18 assessment collected from a hospital that is not eligible for
19 federal matching funds must be returned to the hospital.

20 (i) The state retention amount of the quality assurance
21 assessment collected under subsection (1)(h) must be equal to 13.2%
22 of the federal funds generated by the hospital quality assurance
23 assessment, including the state retention amount. The 13.2% state
24 retention amount described in this subdivision does not apply to
25 the Healthy Michigan plan. In the fiscal year ending September 30,
26 2016, there is a 1-time additional retention amount of up to
27 \$92,856,100.00. In the fiscal year ending September 30, 2017, there
28 is a retention amount of \$105,000,000.00 for the Healthy Michigan
29 plan. Beginning in the fiscal year ending September 30, 2018, and



1 for each fiscal year thereafter, there is a retention amount of
2 \$118,420,600.00 for each fiscal year for the Healthy Michigan plan.
3 The state retention percentage must be applied proportionately to
4 each hospital quality assurance assessment program to determine the
5 retention amount for each program. The state retention amount must
6 be appropriated each fiscal year to the department to support
7 Medicaid expenditures for hospital services and therapy. These
8 funds must offset an identical amount of general fund/general
9 purpose revenue originally appropriated for that purpose. By May
10 31, 2019, the department, the state budget office, and the Michigan
11 Health and Hospital Association shall identify an appropriate
12 retention amount for the fiscal year ending September 30, 2020 and
13 each fiscal year thereafter.

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

16 (a) The quality assurance assessment authorized under this
17 subsection must be used to provide reimbursement to Medicaid
18 ambulance providers. The department may promulgate rules to provide
19 the structure of the quality assurance assessment authorized under
20 this subsection and the level of the assessment.

21 (b) The department shall implement this subsection 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 (c) The total annual collections by the department under this
26 subsection must not exceed \$20,000,000.00.

27 (d) The quality assurance assessment authorized under this
28 subsection must not be collected after October 1, 2023. The quality
29 assurance assessment authorized under this subsection must no



1 longer be collected or assessed if the quality assurance assessment
2 authorized under this subsection is not eligible for federal
3 matching funds.

4 (e) Beginning November 1, 2020, and by November 1 of each year
5 thereafter, the department shall send a notification to each
6 ambulance operation that will be assessed the quality assurance
7 assessment authorized under this subsection during the year in
8 which the notification is sent.

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

11 **(15) For a quality assurance assessment collected under this**
12 **section from a health facility or agency after January 1, 2018, if**
13 **the department determines that a health facility or agency overpaid**
14 **a quality assurance assessment, the department shall refund to the**
15 **health facility or agency the amount overpaid by the health**
16 **facility or agency within 90 days after the determination by the**
17 **department.**

18 (16) ~~(15)~~ As used in this section:

19 (a) "Healthy Michigan plan" means the medical assistance
20 program described in section 105d of the social welfare act, 1939
21 PA 280, MCL 400.105d, that has a federal matching fund rate of not
22 less than 90%.

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

