HOUSE BILL NO. 5004

September 14, 2023, Introduced by Reps. Morse and Witwer and referred to the Committee on Appropriations.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 5801, 6237, 13522, and 20161 (MCL 333.5801, 333.6237, 333.13522, and 333.20161), section 5801 as amended by 2015 PA 91, section 6237 as amended by 2019 PA 75, section 13522 as amended by 1994 PA 100, and section 20161 as amended by 2022 PA 187.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 5801. (1) As used in this part, "child or youth with

1 special health care needs" or "child" means a single or married
2 individual under ~~21~~ **26** years of age whose activity is or may become
3 so restricted by disease or specified medical condition as to
4 reduce the individual's normal capacity for education and self-
5 support.
6 (2) In addition, article 1 contains general definitions and
7 principles of construction applicable to all articles in this code
8 and part 51 contains definitions applicable to this part.
9 Sec. 6237. ~~Until October 1, 2023, the~~ **The** department shall
10 assess a $500.00 fee for licenses on an annual basis upon
11 determining that the applicant has complied with this part and
12 rules promulgated under this part. A licensee shall prominently
13 display the license while it is in effect.
14 Sec. 13522. (1) In promulgating rules ~~pursuant to~~ **under** this
15 part, the department shall avoid requiring dual licensing, insofar
16 as practical. Rules promulgated by the department may provide for
17 **the** recognition of other state or federal licenses as the
18 department considers desirable, subject to registration
19 requirements prescribed by the department. A person ~~who,~~ **that,** on
20 the effective date of an agreement under ~~Act No. 54 of the Public~~
21 ~~Acts of 1965, being sections 3.801 to 3.802 of the Michigan~~
22 ~~Compiled Laws,~~ **1965 PA 54, MCL 3.801 to 3.802,** possesses a license
23 issued by the federal government for a source of ionizing radiation
24 of the type for which the state assumes regulatory responsibility
25 under the agreement, is considered to possess an identical license
26 issued ~~pursuant to~~ **under** this part, which license expires either 90
27 days after receipt of a written notice of termination from the
28 department or on the date of expiration stated in the federal
29 license, whichever occurs first.

(2) The department may promulgate rules to establish a schedule of fees to be paid by applicants for licenses for radioactive materials and devices and equipment utilizing the radioactive materials.

(3) Except as otherwise provided in this subsection, the department may promulgate rules to establish a schedule of fees to be paid by an applicant for a license for other sources of ionizing radiation and the renewal of the license, and by a person possessing sources of ionizing radiation that are subject to registration. The registration or registration renewal fee for a radiation machine registered under this part is ~~$45.00~~ **$104.88** for the first veterinary or dental x-ray or electron tube and ~~$25.00~~ **$58.19** for each additional veterinary or dental x-ray or electron tube annually, or ~~$75.00~~ **$174.88** annually per nonveterinary or nondental x-ray or electron tube. The department shall not assess a fee for the amendment of a radiation machine registration certificate. In addition, the department shall assess a fee of ~~$100.00~~ **$233.23** for each follow-up inspection due to noncompliance during the same year. The department may accept a written certification from the licensee or registrant that the items of noncompliance have been corrected instead of performing a follow-up inspection. If the department does not inspect a source of ionizing radiation for a period of 5 consecutive years, the licensee or registrant of the source of ionizing radiation does not have to pay further license or registration fees as to that source of ionizing radiation until the first license or registration renewal date following the time an inspection of the source of ionizing radiation is made.

(4) A fee collected under this part ~~shall~~ **must** be deposited in

the state treasury and credited to the general fund of this state.

(5) Except as otherwise provided in subsection (6), the department shall assess the following nonrefundable fees in connection with mammography authorization:

(a) Inspection, per radiation machine............ $ ~~100.00~~**233.23**

(b) Reinspection for reinstatement of mammography authorization, per radiation machine.................. $ ~~100.00~~**233.23**

(c) Department evaluation of compliance with section 13523(2)(a), per radiation machine............ $ ~~700.00~~**1,567.45**

Each reevaluation of a radiation machine due to failure during the previous evaluation, relocation of the radiation machine, or similar changes that could affect earlier evaluation results..................... $ ~~300.00~~**671.65**

(6) If an applicant for mammography authorization submits an evaluation report issued by the American ~~college of radiology~~ **College of Radiology** that evidences compliance with section 13523(2)(a), the department shall waive the fee under subsection (5) for department evaluation of compliance with that provision.

(7) Except as otherwise provided in subsections (3) and (6), the department shall not waive a fee required under this section.

(8) The department shall adjust on an annual basis the fees prescribed by subsections (3) and (5) by an amount determined by the state treasurer to reflect the cumulative annual percentage change in the Detroit ~~consumer price index,~~ **Consumer Price Index,** not to exceed 5%. As used in this subsection, "Detroit ~~consumer~~

1 ~~price index"~~ **Consumer Price Index"** means the most comprehensive
2 index of consumer prices available for the Detroit area from the
3 ~~bureau of labor statistics~~ **Bureau of Labor Statistics** of the United
4 States ~~department of labor.~~**Department of Labor.**
5 Sec. 20161. (1) The department shall assess fees and other
6 assessments for health facility and agency licenses and
7 certificates of need on an annual basis as provided in this
8 article. Until October 1, ~~2023,~~ **2028,** except as otherwise provided
9 in this article, fees and assessments must be paid as provided in
10 the following schedule:
11 (a) Freestanding surgical
12 outpatient facilities..............$500.00 per facility license.
13 (b) Hospitals .... $500.00 per facility license and
14 $10.00 per licensed bed.
15 (c) Nursing homes, county
16 medical care facilities, and
17 hospital long-term care units .....$500.00 per facility license and
18 $3.00 per licensed bed over 100
19 licensed beds.
20 (d) Homes for the aged ...... **$500.00 per facility license and**
21 $6.27 per licensed bed.
22 (e) Hospice agencies .... $500.00 per agency license.
23 (f) Hospice residences ...... $500.00 per facility license and
24 $5.00 per licensed bed.
25 (g) Subject to subsection
26 (11), quality assurance assessment
27 for nursing homes and hospital
28 long-term care units ....an amount resulting in not more

than 6% of total industry revenues.

(h) Subject to subsection (12), quality assurance assessment for hospitals .... at 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), **(d)**, (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:

(a) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to ~~1396w-6.~~**1396w-7.**

(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

1 or more but less than $10,000,000.00, an additional fee of
2 $8,000.00 is added to the base fee. For a project requiring a
3 projected capital expenditure of $10,000,000.00 or more, an
4 additional fee of $12,000.00 is added to the base fee.
5 (b) In addition to the fees under subdivision (a), the
6 applicant shall pay $3,000.00 for any designated complex project
7 including a project scheduled for comparative review or for a
8 consolidated licensed health facility application for acquisition
9 or replacement.
10 (c) If required by the department, the applicant shall pay
11 $1,000.00 for a certificate of need application that receives
12 expedited processing at the request of the applicant.
13 (d) The department shall charge a fee of $500.00 to review any
14 letter of intent requesting or resulting in a waiver from
15 certificate of need review and any amendment request to an approved
16 certificate of need.
17 (e) A health facility or agency that offers certificate of
18 need covered clinical services shall pay $100.00 for each
19 certificate of need approved covered clinical service as part of
20 the certificate of need annual survey at the time of submission of
21 the survey data.
22 (f) Except as otherwise provided in this section, the
23 department shall use the fees collected under this subsection only
24 to fund the certificate of need program. Funds remaining in the
25 certificate of need program at the end of the fiscal year do not
26 lapse to the general fund but remain available to fund the
27 certificate of need program in subsequent years.
28 (4) A license issued under this part is effective for no
29 longer than 1 year after the date of issuance.

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

1 assessment must 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 must 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 this state shall not receive the increased per diem
14 Medicaid reimbursement rates under this subdivision until all of
15 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, must 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
28 assessed.
29 (c) Within 30 days after September 30, 2005, the department

1 shall submit an application to the 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 assessment
5 rate for a nursing home or hospital long-term care unit with less
6 than 40 licensed beds or with the maximum number, or more than the
7 maximum number, of licensed beds necessary to secure federal
8 approval of the application is $2.00 per non-Medicare patient day
9 of care provided within the immediately preceding year or a rate as
10 otherwise altered on the application for the waiver to obtain
11 federal approval. If the waiver is approved, for all other nursing
12 homes and long-term care units the quality assurance assessment
13 rate is to be calculated by dividing the total statewide maximum
14 allowable assessment permitted under subsection (1)(g) less the
15 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, must be
24 assessed in the first quarter after federal approval of the waiver
25 and must be subsequently assessed on October 1 of each following
26 year, and is payable on a quarterly basis, with the first payment
27 due 90 days after the date the assessment is assessed.
28 (*ii*) If the waiver is approved, continuing care retirement
29 centers are exempt from the quality assurance assessment if the

1 continuing care retirement center requires each center resident to
2 provide an initial life interest payment of $150,000.00, on
3 average, per resident to ensure payment for that resident's
4 residency and services and the continuing care retirement center
5 utilizes all of the initial life interest payment before the
6 resident becomes eligible for medical assistance under the state's
7 Medicaid plan. As used in this subparagraph, "continuing care
8 retirement center" means a nursing care facility that provides
9 independent living services, assisted living services, and nursing
10 care and medical treatment services, in a campus-like setting that
11 has shared facilities or common areas, or both.
12 (d) Beginning May 10, 2002, the department shall increase the
13 per diem nursing home Medicaid reimbursement rates for the balance
14 of that year. For each subsequent year in which the quality
15 assurance assessment is assessed and collected, the department
16 shall maintain the Medicaid nursing home reimbursement payment
17 increase financed by the quality assurance assessment.
18 (e) The department shall implement this section 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 (f) If a nursing home or a hospital long-term care unit fails
23 to pay the assessment required by subsection (1)(g), the department
24 may assess the nursing home or hospital long-term care unit a
25 penalty of 5% of the assessment for each month that the assessment
26 and penalty are not paid up to a maximum of 50% of the assessment.
27 The 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.

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

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

(i) The quality assurance assessment collected under subsection (1)(g) must 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.

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

(k) The state retention amount of the quality assurance assessment collected under subsection (1)(g) must be equal to 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 must be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) ~~Beginning October 1, 2023, the department shall not assess or collect the quality assurance assessment or apply for federal~~

1 ~~matching funds.~~ The quality assurance assessment collected under
2 subsection (1)(g) must not be assessed or collected after September
3 30, 2011 if the quality assurance assessment is not eligible for
4 federal matching funds. Any portion of the quality assurance
5 assessment collected from a nursing home or hospital long-term care
6 unit that is not eligible for federal matching funds must be
7 returned to the nursing home or hospital long-term care unit.
8 (12) The quality assurance dedication is an earmarked
9 assessment collected under subsection (1)(h). That assessment and
10 all federal matching funds attributed to that assessment must be
11 used only for the following purpose and under the following
12 specific circumstances:
13 (a) To maintain the increased Medicaid reimbursement rate
14 increases as provided for in subdivision (c).
15 (b) The quality assurance assessment must be assessed on all
16 net patient revenue, before deduction of expenses, less Medicare
17 net revenue, as reported in the most recently available Medicare
18 cost report and is payable on a quarterly basis, with the first
19 payment due 90 days after the date the assessment is assessed. As
20 used in this subdivision, "Medicare net revenue" includes Medicare
21 payments and amounts collected for coinsurance and deductibles.
22 (c) Beginning October 1, 2002, the department shall increase
23 the hospital Medicaid reimbursement rates for the balance of that
24 year. For each subsequent year in which the quality assurance
25 assessment is assessed and collected, the department shall maintain
26 the hospital Medicaid reimbursement rate increase financed by the
27 quality assurance assessments.
28 (d) The department shall implement this section in a manner
29 that complies with federal requirements necessary to ensure that

1 the quality assurance assessment qualifies for federal matching
2 funds.
3 (e) If a hospital fails to pay the assessment required by
4 subsection (1)(h), the department may assess the hospital a penalty
5 of 5% of the assessment for each month that the assessment and
6 penalty are not paid up to a maximum of 50% of the assessment. The
7 department may also refer for collection to the department of
8 treasury past due amounts consistent with section 13 of 1941 PA
9 122, MCL 205.13.
10 (f) The hospital quality assurance assessment fund is
11 established in the state treasury. The department shall deposit the
12 revenue raised through the quality assurance assessment with the
13 state treasurer for deposit in the hospital quality assurance
14 assessment fund.
15 (g) In each fiscal year governed by this subsection, the
16 quality assurance assessment must only be collected and expended if
17 Medicaid hospital inpatient DRG and outpatient reimbursement rates
18 and disproportionate share hospital and graduate medical education
19 payments are not below the level of rates and payments in effect on
20 April 1, 2002 as a direct result of the quality assurance
21 assessment collected under subsection (1)(h), except as provided in
22 subdivision (h).
23 (h) The quality assurance assessment collected under
24 subsection (1)(h) must not be assessed or collected after September
25 30, 2011 if the quality assurance assessment is not eligible for
26 federal matching funds. Any portion of the quality assurance
27 assessment collected from a hospital that is not eligible for
28 federal matching funds must be returned to the hospital.
29 (i) The state retention amount of the quality assurance

1 assessment collected under subsection (1)(h) must be equal to 13.2%
2 of the federal funds generated by the hospital quality assurance
3 assessment, including the state retention amount. The 13.2% state
4 retention amount described in this subdivision does not apply to
5 the Healthy Michigan plan. ~~In the fiscal year ending September 30,~~
6 ~~2016, there is a 1-time additional retention amount of up to~~
7 ~~$92,856,100.00. In the fiscal year ending September 30, 2017, there~~
8 ~~is a retention amount of $105,000,000.00 for the Healthy Michigan~~
9 ~~plan. Beginning in the fiscal year ending September 30, 2018, and~~
10 ~~for each fiscal year thereafter, there is a retention amount of~~
11 ~~$118,420,600.00 for each fiscal year for the Healthy Michigan plan.~~
12 **By May 31 of each year, the department, the state budget office,**
13 **and the Michigan Health and Hospital Association shall identify an**
14 **appropriate retention amount for the Healthy Michigan plan.** The
15 state retention percentage must be applied proportionately to each
16 hospital quality assurance assessment program to determine the
17 retention amount for each program. The state retention amount must
18 be appropriated each fiscal year to the department to support
19 Medicaid expenditures for hospital services and therapy. These
20 funds must offset an identical amount of general fund/general
21 purpose revenue originally appropriated for that purpose. ~~By May~~
22 ~~31, 2019, the department, the state budget office, and the Michigan~~
23 ~~Health and Hospital Association shall identify an appropriate~~
24 ~~retention amount for the fiscal year ending September 30, 2020 and~~
25 ~~each fiscal year thereafter.~~
26 (13) The department may establish a quality assurance
27 assessment to increase ambulance reimbursement as follows:
28 (a) The quality assurance assessment authorized under this
29 subsection must be used to provide reimbursement to Medicaid

1 ambulance providers. The department may promulgate rules to provide
2 the structure of the quality assurance assessment authorized under
3 this subsection and the level of the assessment.
4 (b) The department shall implement this subsection in a manner
5 that complies with federal requirements necessary to ensure that
6 the quality assurance assessment qualifies for federal matching
7 funds.
8 (c) The total annual collections by the department under this
9 subsection must not exceed $20,000,000.00.
10 (d) ~~The quality assurance assessment authorized under this~~
11 ~~subsection must not be collected after October 1, 2023.~~ The quality
12 assurance assessment authorized under this subsection must no
13 longer be collected or assessed if the quality assurance assessment
14 authorized under this subsection is not eligible for federal
15 matching funds.
16 (e) ~~Beginning November 1, 2020, and by~~ **By** November 1 of each
17 year, ~~thereafter,~~ the department shall send a notification to each
18 ambulance operation that will be assessed the quality assurance
19 assessment authorized under this subsection during the year in
20 which the notification is sent.
21 (14) The quality assurance assessment provided for under this
22 section is a tax that is levied on a health facility or agency.
23 ~~(15) For the fiscal year ending September 30, 2020 only,~~
24 ~~$3,000,000.00 of the money in the certificate of need program is~~
25 ~~transferred to and must be deposited into the general fund.~~
26 **(15)** ~~(16)~~ As used in this section:
27 (a) "Healthy Michigan plan" means the medical assistance
28 program described in section 105d of the social welfare act, 1939
29 PA 280, MCL 400.105d, that has a federal matching fund rate of not

1 less than 90%.

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