STATE OF MICHIGAN
96TH LEGISLATURE
REGULAR SESSION OF 2011

Introduced by Rep. Lori

ENROLLED HOUSE BILL No. 4734

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," by amending section 20161 (MCL 333.20161), as amended by 2008 PA 277.

The People of the State of Michigan enact:

Sec. 20161. (1) The department shall assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Except as otherwise provided in this article, fees and assessments shall be paid in accordance with the following schedule:

(a) Freestanding surgical outpatient facilities	$238.00 per facility.
(b) Hospitals	$8.28 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units	$2.20 per licensed bed.
(d) Homes for the aged	$6.27 per licensed bed.
(e) Clinical laboratories	$475.00 per laboratory.
(f) Hospice residences	$200.00 per license survey; and $20.00 per licensed bed.
(g) Subject to subsection (13), quality assurance assessment for nursing homes and hospital long-term care units	an amount resulting in not more than 6% of total industry revenues.

(h) Subject to subsection (14), 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 (14)(a) and (i).

(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) The base fee for a certificate of need is $1,500.00 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 $4,000.00 shall be added to the base fee. For a project requiring a projected capital expenditure of $4,000,000.00 or more, an additional fee of $7,000.00 shall be added to the base fee. The department of community health shall use the fees collected under this subsection only to fund the certificate of need program. Funds remaining in the certificate of need program at the end of the fiscal year shall not lapse to the general fund but shall remain available to fund the certificate of need program in subsequent years.

(4) If licensure is for more than 1 year, the fees described in subsection (1) are multiplied by the number of years for which the license is issued, and the total amount of the fees shall be collected in the year in which the license is issued.

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

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

(7) The department may charge a fee to recover the cost of purchase or production and distribution of proficiency evaluation samples that are supplied to clinical laboratories pursuant to section 20521(3).

(8) In addition to the fees imposed under subsection (1), a clinical laboratory shall submit a fee of $25.00 to the department for each reissuance during the licensure period of the clinical laboratory's license.

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

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

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

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

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

(a) The quality assurance assessment and all federal matching funds attributed to that assessment shall be used to finance medicaid nursing home reimbursement payments. Only licensed nursing homes and hospital long-term care units that are assessed the quality assurance assessment and participate in the medicaid program are eligible for increased per diem medicaid reimbursement rates under this subdivision. A nursing home or long-term care unit that is assessed the quality assurance assessment and that does not pay the assessment required under subsection (1)(g) in accordance with subdivision (c)(*i*) or in accordance with a written payment agreement with the state shall not receive the increased per diem medicaid reimbursement rates under this subdivision until all of its outstanding quality assurance assessments and any penalties assessed pursuant to subdivision (f) have been paid in full. Nothing in this subdivision shall be construed to authorize or require the department to overspend tax revenue in violation of the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

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

(c) Within 30 days after September 30, 2005, the department shall submit an application to the federal centers for medicare and medicaid services to request a waiver pursuant to 42 CFR 433.68(e) to implement this subdivision as follows:

(*i*) If the waiver is approved, the quality assurance assessment rate for a nursing home or hospital long-term care unit with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application is $2.00 per nonmedicare patient day of care provided within the immediately preceding year or a rate as otherwise altered on the application for the waiver to obtain federal approval. If the waiver is approved, for all other nursing homes and long-term care units the quality assurance assessment rate is to be calculated by dividing the total statewide maximum allowable assessment permitted under subsection (1)(g) less the total amount to be paid by the nursing homes and long-term care units with less than 40 or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application by the total number of nonmedicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, shall be assessed in the first quarter after federal approval of the waiver and shall be subsequently assessed on October 1 of each following year, and is payable on a quarterly basis, the first payment due 90 days after the date the assessment is assessed.

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

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

(e) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment qualifies for federal matching funds.

(f) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection (1)(g), the department of community health may assess the nursing home or hospital long-term care unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(g) The medicaid nursing home quality assurance assessment fund is established in the state treasury. The department of community health 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 of community health 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) shall 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 shall 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 pursuant to subsection (1)(g) shall 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 shall be appropriated each fiscal year to the department of community health 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, 2015, the department shall no longer 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 be assessed or collected after September 30, 2011, in the event that 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.

(14) 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, the first payment due 90 days after the date the assessment is assessed. As used in this subdivision, "medicare net revenue" includes medicare payments and amounts collected for coinsurance and deductibles.

(c) Beginning October 1, 2002, the department of community health shall increase the hospital medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department of community health shall maintain the hospital medicaid reimbursement rate increase financed by the quality assurance assessments.

(d) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment qualifies for federal matching funds.

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

(f) The hospital quality assurance assessment fund is established in the state treasury. The department of community health shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the hospital quality assurance assessment fund.

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

(h) The quality assurance assessment collected under subsection (1)(h) shall no longer be assessed or collected after September 30, 2011 in the event that the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds shall be returned to the hospital.

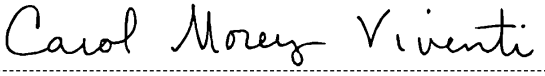
(i) The state retention amount of the quality assurance assessment collected pursuant to subsection (1)(h) shall be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The state retention percentage shall be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount shall be appropriated each fiscal year to the department of community health to support medicaid expenditures for hospital services and therapy. These funds shall offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

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

(16) As used in this section, "medicaid" means that term as defined in section 22207.

This act is ordered to take immediate effect.

Clerk of the House of Representatives



Secretary of the Senate

Approved .....

.....

Governor