

HOUSE SUBSTITUTE FOR  
SENATE BILL NO. 957

A bill to amend 1978 PA 368, entitled  
"Public health code,"  
by amending section 20161 (MCL 333.20161), as amended by 2015 PA  
104.

**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, 2019, except as otherwise provided in  
5 this article, fees and assessments shall be paid as provided in the  
6 following schedule:

7           (a) Freestanding surgical  
8 outpatient facilities.....\$500.00 per facility

1 license.

2 (b) Hospitals.....\$500.00 per facility

3 license and \$10.00 per

4 licensed bed.

5 (c) Nursing homes, county

6 medical care facilities, and

7 hospital long-term care units.....\$500.00 per facility

8 license and \$3.00 per

9 licensed bed over 100

10 licensed beds.

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

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

13 (f) Hospice residences.....\$500.00 per facility

14 license and \$5.00 per

15 licensed bed.

16 (g) Subject to subsection

17 (11), quality assurance assessment

18 for nursing homes and hospital

19 long-term care units.....an amount resulting

20 in not more than 6%

21 of total industry

22 revenues.

23 (h) Subject to subsection

24 (12), quality assurance assessment

25 for hospitals.....at a fixed or variable

26 rate that generates

27 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 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) 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.

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

6 (c) If required by the department, the applicant shall pay  
7 \$1,000.00 for a certificate of need application that receives  
8 expedited processing at the request of the applicant.

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

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

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

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

26 (5) Fees described in this section are payable to the  
27 department at the time an application for a license, permit, or

1 certificate is submitted. If an application for a license, permit,  
2 or certificate is denied or if a license, permit, or certificate is  
3 revoked before its expiration date, the department shall not refund  
4 fees paid to the department.

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

10 (7) The cost of licensure activities shall be supported by  
11 license fees.

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

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

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

26 (11) The quality assurance assessment collected under  
27 subsection (1)(g) and all federal matching funds attributed to that

1 assessment shall 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 shall 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 ~~the~~ **THIS** state shall not receive the increased per  
14 diem Medicaid reimbursement rates under this subdivision until all  
15 of 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, ~~and~~ shall 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

1 assessed.

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

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

1 year, and is payable on a quarterly basis, **WITH** the first payment  
2 due 90 days after the date the assessment is assessed.

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

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

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

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



1 may assess the nursing home or hospital long-term care unit a  
2 penalty of 5% of the assessment for each month that the assessment  
3 and penalty are not paid up to a maximum of 50% of the assessment.  
4 The department may also refer for collection to the department of  
5 treasury past due amounts consistent with section 13 of 1941 PA  
6 122, MCL 205.13.

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

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

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

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

25 (k) The state retention amount of the quality assurance  
26 assessment collected under subsection (1)(g) shall be equal to  
27 13.2% of the federal funds generated by the nursing homes and

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

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

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

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

24 (b) The quality assurance assessment shall be assessed on all  
25 net patient revenue, before deduction of expenses, less Medicare  
26 net revenue, as reported in the most recently available Medicare  
27 cost report and is payable on a quarterly basis, **WITH** the first

1 payment due 90 days after the date the assessment is assessed. As  
2 used in this subdivision, "Medicare net revenue" includes Medicare  
3 payments and amounts collected for coinsurance 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 only be collected and expended

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

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

14 (i) The state retention amount of the quality assurance  
15 assessment collected under subsection (1)(h) shall be equal to  
16 13.2% of the federal funds generated by the hospital quality  
17 assurance assessment, including the state retention amount. **THE**  
18 **13.2% STATE RETENTION AMOUNT DESCRIBED IN THIS SUBDIVISION DOES NOT**  
19 **APPLY TO THE HEALTHY MICHIGAN PLAN.** In the fiscal year ending  
20 September 30, 2016, there is a 1-time additional retention amount  
21 of up to \$92,856,100.00. **BEGINNING IN THE FISCAL YEAR ENDING**  
22 **SEPTEMBER 30, 2017, AND FOR EACH FISCAL YEAR THEREAFTER, THERE IS A**  
23 **RETENTION AMOUNT OF \$105,000,000.00 FOR EACH FISCAL YEAR FOR THE**  
24 **HEALTHY MICHIGAN PLAN.** The state retention percentage shall be  
25 applied proportionately to each hospital quality assurance  
26 assessment program to determine the retention amount for each  
27 program. The state retention amount shall be appropriated each

1 fiscal year to the department to support Medicaid expenditures for  
2 hospital services and therapy. These funds shall offset an  
3 identical amount of general fund/general purpose revenue originally  
4 appropriated for that purpose. **BY MAY 31, 2019, THE DEPARTMENT, THE**  
5 **STATE BUDGET OFFICE, AND THE MICHIGAN HEALTH AND HOSPITAL**  
6 **ASSOCIATION SHALL IDENTIFY AN APPROPRIATE RETENTION AMOUNT FOR THE**  
7 **FISCAL YEAR ENDING SEPTEMBER 30, 2020 AND EACH FISCAL YEAR**  
8 **THEREAFTER.**

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

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

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

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

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

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

3           (15) As used in this section: 7

4           **(A) "HEALTHY MICHIGAN PLAN" MEANS THE MEDICAL ASSISTANCE PLAN**  
5 **DESCRIBED IN SECTION 105D OF THE SOCIAL WELFARE ACT, 1939 PA 280,**  
6 **MCL 400.105D, THAT HAS A FEDERAL MATCHING FUND RATE OF NOT LESS**  
7 **THAN 90%.**

8           **(B) "Medicaid" means that term as defined in section 22207.**