

**SUBSTITUTE FOR
HOUSE BILL NO. 4830**

A bill to amend 1978 PA 368, entitled
"Public health code,"
by amending section 20161 (MCL 333.20161), as amended by 2019 PA
74.

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



- 1 (a) Freestanding surgical
- 2 outpatient facilities.....\$500.00 per facility license.
- 3 (b) Hospitals \$500.00 per facility license and
- 4 \$10.00 per licensed bed.
- 5 (c) Nursing homes, county
- 6 medical care facilities, and
- 7 hospital long-term care units\$500.00 per facility license and
- 8 \$3.00 per licensed bed over 100
- 9 licensed beds.
- 10 (d) Homes for the aged \$6.27 per licensed bed.
- 11 (e) Hospice agencies \$500.00 per agency license.
- 12 (f) Hospice residences \$500.00 per facility license and
- 13 \$5.00 per licensed bed.
- 14 (g) Subject to subsection
- 15 (11), quality assurance assessment
- 16 for nursing homes and hospital
- 17 long-term care unitsan amount resulting in not more
- 18 than 6% of total industry
- 19 revenues.
- 20 (h) Subject to subsection
- 21 (12), quality assurance assessment
- 22 for hospitalsat a fixed or variable rate that
- 23 generates funds not more than
- 24 the maximum allowable under the
- 25 federal matching requirements,
- 26 after consideration for the
- 27 amounts in subsection (12) (a)
- 28 and (i).



1 (i) Initial licensure
2 application fee for subdivisions
3 (a), (b), (c), (e), and (f)\$2,000.00 per initial license.

4 (2) If a hospital requests the department to conduct a
5 certification survey for purposes of title XVIII or title XIX, the
6 hospital shall pay a license fee surcharge of \$23.00 per bed. As
7 used in this subsection, "title XVIII" and "title XIX" mean those
8 terms as defined in section 20155.

9 (3) All of the following apply to the assessment under this
10 section for certificates of need:

11 (a) The base fee for a certificate of need is \$3,000.00 for
12 each application. For a project requiring a projected capital
13 expenditure of more than \$500,000.00 but less than \$4,000,000.00,
14 an additional fee of \$5,000.00 is added to the base fee. For a
15 project requiring a projected capital expenditure of \$4,000,000.00
16 or more but less than \$10,000,000.00, an additional fee of
17 \$8,000.00 is added to the base fee. For a project requiring a
18 projected capital expenditure of \$10,000,000.00 or more, an
19 additional fee of \$12,000.00 is added to the base fee.

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

25 (c) If required by the department, the applicant shall pay
26 \$1,000.00 for a certificate of need application that receives
27 expedited processing at the request of the applicant.

28 (d) The department shall charge a fee of \$500.00 to review any
29 letter of intent requesting or resulting in a waiver from



1 certificate of need review and any amendment request to an approved
2 certificate of need.

3 (e) A health facility or agency that offers certificate of
4 need covered clinical services shall pay \$100.00 for each
5 certificate of need approved covered clinical service as part of
6 the certificate of need annual survey at the time of submission of
7 the survey data.

8 (f) The department shall use the fees collected under this
9 subsection only to fund the certificate of need program. Funds
10 remaining in the certificate of need program at the end of the
11 fiscal year do not lapse to the general fund but remain available
12 to fund the certificate of need program in subsequent years.

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

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

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

26 (7) The cost of licensure activities must be supported by
27 license fees.

28 (8) The application fee for a waiver under section 21564 is
29 \$200.00 plus \$40.00 per hour for the professional services and



1 travel expenses directly related to processing the application. The
2 travel expenses must be calculated in accordance with the state
3 standardized travel regulations of the department of technology,
4 management, and budget in effect at the time of the travel.

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

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

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

17 (a) The quality assurance assessment and all federal matching
18 funds attributed to that assessment must be used to finance
19 Medicaid nursing home reimbursement payments. Only licensed nursing
20 homes and hospital long-term care units that are assessed the
21 quality assurance assessment and participate in the Medicaid
22 program are eligible for increased per diem Medicaid reimbursement
23 rates under this subdivision. A nursing home or long-term care unit
24 that is assessed the quality assurance assessment and that does not
25 pay the assessment required under subsection (1)(g) in accordance
26 with subdivision (c)(i) or in accordance with a written payment
27 agreement with this state shall not receive the increased per diem
28 Medicaid reimbursement rates under this subdivision until all of
29 its outstanding quality assurance assessments and any penalties



1 assessed under subdivision (f) have been paid in full. This
2 subdivision does not authorize or require the department to
3 overspend tax revenue in violation of the management and budget
4 act, 1984 PA 431, MCL 18.1101 to 18.1594.

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

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

18 (i) If the waiver is approved, the quality assurance assessment
19 rate for a nursing home or hospital long-term care unit with less
20 than 40 licensed beds or with the maximum number, or more than the
21 maximum number, of licensed beds necessary to secure federal
22 approval of the application is \$2.00 per non-Medicare patient day
23 of care provided within the immediately preceding year or a rate as
24 otherwise altered on the application for the waiver to obtain
25 federal approval. If the waiver is approved, for all other nursing
26 homes and long-term care units the quality assurance assessment
27 rate is to be calculated by dividing the total statewide maximum
28 allowable assessment permitted under subsection (1)(g) less the
29 total amount to be paid by the nursing homes and long-term care



1 units with less than 40 licensed beds or with the maximum number,
2 or more than the maximum number, of licensed beds necessary to
3 secure federal approval of the application by the total number of
4 non-Medicare patient days of care provided within the immediately
5 preceding year by those nursing homes and long-term care units with
6 more than 39 licensed beds, but less than the maximum number of
7 licensed beds necessary to secure federal approval. The quality
8 assurance assessment, as provided under this subparagraph, must be
9 assessed in the first quarter after federal approval of the waiver
10 and must be subsequently assessed on October 1 of each following
11 year, and is payable on a quarterly basis, with the first payment
12 due 90 days after the date the assessment is assessed.

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

26 (d) Beginning May 10, 2002, the department shall increase the
27 per diem nursing home Medicaid reimbursement rates for the balance
28 of that year. For each subsequent year in which the quality
29 assurance assessment is assessed and collected, the department



1 shall maintain the Medicaid nursing home reimbursement payment
2 increase financed by the quality assurance assessment.

3 (e) The department shall implement this section in a manner
4 that complies with federal requirements necessary to ensure that
5 the quality assurance assessment qualifies for federal matching
6 funds.

7 (f) If a nursing home or a hospital long-term care unit fails
8 to pay the assessment required by subsection (1)(g), the department
9 may assess the nursing home or hospital long-term care unit a
10 penalty of 5% of the assessment for each month that the assessment
11 and penalty are not paid up to a maximum of 50% of the assessment.
12 The department may also refer for collection to the department of
13 treasury past due amounts consistent with section 13 of 1941 PA
14 122, MCL 205.13.

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

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

22 (i) The quality assurance assessment collected under
23 subsection (1)(g) must be prorated on a quarterly basis for any
24 licensed beds added to or subtracted from a nursing home or
25 hospital long-term care unit since the immediately preceding July
26 1. Any adjustments in payments are due on the next quarterly
27 installment due date.

28 (j) In each fiscal year governed by this subsection, Medicaid
29 reimbursement rates must not be reduced below the Medicaid



1 reimbursement rates in effect on April 1, 2002 as a direct result
2 of the quality assurance assessment collected under subsection
3 (1)(g).

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

13 (l) Beginning October 1, 2023, the department shall not assess
14 or collect the quality assurance assessment or apply for federal
15 matching funds. The quality assurance assessment collected under
16 subsection (1)(g) must not be assessed or collected after September
17 30, 2011 if the quality assurance assessment is not eligible for
18 federal matching funds. Any portion of the quality assurance
19 assessment collected from a nursing home or hospital long-term care
20 unit that is not eligible for federal matching funds must be
21 returned to the nursing home or hospital long-term care unit.

22 (12) The quality assurance dedication is an earmarked
23 assessment collected under subsection (1)(h). That assessment and
24 all federal matching funds attributed to that assessment must be
25 used only for the following purpose and under the following
26 specific circumstances:

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

29 (b) The quality assurance assessment must be assessed on all



1 net patient revenue, before deduction of expenses, less Medicare
2 net revenue, as reported in the most recently available Medicare
3 cost report and is payable on a quarterly basis, with the first
4 payment due 90 days after the date the assessment is assessed. As
5 used in this subdivision, "Medicare net revenue" includes Medicare
6 payments and amounts collected for coinsurance and deductibles.

7 (c) Beginning October 1, 2002, the department shall increase
8 the hospital Medicaid reimbursement rates for the balance of that
9 year. For each subsequent year in which the quality assurance
10 assessment is assessed and collected, the department shall maintain
11 the hospital Medicaid reimbursement rate increase financed by the
12 quality assurance assessments.

13 (d) The department shall implement this section in a manner
14 that complies with federal requirements necessary to ensure that
15 the quality assurance assessment qualifies for federal matching
16 funds.

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

24 (f) The hospital quality assurance assessment fund is
25 established in the state treasury. The department shall deposit the
26 revenue raised through the quality assurance assessment with the
27 state treasurer for deposit in the hospital quality assurance
28 assessment fund.

29 (g) In each fiscal year governed by this subsection, the



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

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

14 (i) The state retention amount of the quality assurance
15 assessment collected under subsection (1)(h) must be equal to 13.2%
16 of the federal funds generated by the hospital quality assurance
17 assessment, including the state retention amount. The 13.2% state
18 retention amount described in this subdivision does not apply to
19 the Healthy Michigan plan. In the fiscal year ending September 30,
20 2016, there is a 1-time additional retention amount of up to
21 \$92,856,100.00. In the fiscal year ending September 30, 2017, there
22 is a retention amount of \$105,000,000.00 for the Healthy Michigan
23 plan. Beginning in the fiscal year ending September 30, 2018, and
24 for each fiscal year thereafter, there is a retention amount of
25 \$118,420,600.00 for each fiscal year for the Healthy Michigan ~~Plan.~~
26 **plan.** The state retention percentage must be applied
27 proportionately to each hospital quality assurance assessment
28 program to determine the retention amount for each program. The
29 state retention amount must be appropriated each fiscal year to the



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

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

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

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

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

21 (d) The quality assurance assessment authorized under this
22 subsection must not be collected after October 1, 2023. The quality
23 assurance assessment authorized under this subsection must no
24 longer be collected or assessed if the quality assurance assessment
25 authorized under this subsection is not eligible for federal
26 matching funds.

27 **(e) Beginning November 1, 2020, and by November 1 of each year**
28 **thereafter, the department shall send a notification to each**
29 **ambulance operation that will be assessed the quality assurance**



1 **assessment authorized under this subsection during the year in**
2 **which the notification is sent.**

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
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.

