

SUBSTITUTE FOR  
HOUSE BILL NO. 4787

A bill to amend 1978 PA 368, entitled  
"Public health code,"  
by amending section 20161 (MCL 333.20161), as amended by 2011 PA  
144.

**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. Except as otherwise provided in this article, fees and  
5 assessments shall be paid ~~in accordance with~~ **AS PROVIDED IN** the  
6 following schedule:

- 7           (a) Freestanding surgical  
8 outpatient facilities.....\$238.00 per facility.  
9           (b) Hospitals.....\$8.28 per licensed bed.  
10          (c) Nursing homes, county



1 medical care facilities, and  
 2 hospital long-term care units.....\$2.20 per licensed bed.  
 3 (d) Homes for the aged.....\$6.27 per licensed bed.  
 4 (e) Clinical laboratories.....\$475.00 per laboratory.  
 5 (f) Hospice residences.....\$200.00 per license  
 6 survey; and \$20.00 per  
 7 licensed bed.

8 (g) Subject to subsection  
 9 (13), quality assurance assessment  
 10 for nursing homes and hospital  
 11 long-term care units.....an amount resulting  
 12 in not more than 6%  
 13 of total industry  
 14 revenues.

15 (h) Subject to subsection  
 16 (14), quality assurance assessment  
 17 for hospitals.....at a fixed or variable  
 18 rate that generates  
 19 funds not more than the  
 20 maximum allowable under  
 21 the federal matching  
 22 requirements, after  
 23 consideration for the  
 24 amounts in subsection  
 25 (14)(a) and (i).

26 (2) If a hospital requests the department to conduct a  
 27 certification survey for purposes of title XVIII or title XIX of  
 28 the social security act, the hospital shall pay a license fee  
 29 surcharge of \$23.00 per bed. As used in this subsection, "title  
 30 XVIII" and "title XIX" mean those terms as defined in section



1 20155.

2 (3) ALL OF THE FOLLOWING APPLY TO THE ASSESSMENT UNDER THIS  
3 SECTION FOR CERTIFICATES OF NEED:

4 (A) The base fee for a certificate of need is ~~\$1,500.00~~  
5 \$3,000.00 for each application. For a project requiring a  
6 projected capital expenditure of more than \$500,000.00 but less  
7 than \$4,000,000.00, an additional fee of ~~\$4,000.00 shall be~~  
8 \$5,000.00 IS added to the base fee. For a project requiring a  
9 projected capital expenditure of \$4,000,000.00 or more BUT LESS  
10 THAN \$10,000,000.00, an additional fee of ~~\$7,000.00 shall be~~  
11 \$8,000.00 IS added to the base fee. FOR A PROJECT REQUIRING A  
12 PROJECTED CAPITAL EXPENDITURE OF \$10,000,000.00 OR MORE, AN  
13 ADDITIONAL FEE OF \$12,000.00 IS ADDED TO THE BASE FEE.

14 (B) IN ADDITION TO THE FEES UNDER SUBDIVISION (A), THE  
15 APPLICANT SHALL PAY \$3,000.00 FOR ANY DESIGNATED COMPLEX PROJECT  
16 INCLUDING A PROJECT SCHEDULED FOR COMPARATIVE REVIEW OR FOR A  
17 CONSOLIDATED LICENSED HEALTH FACILITY APPLICATION FOR ACQUISITION  
18 OR REPLACEMENT.

19 (C) IF REQUIRED BY THE DEPARTMENT, THE APPLICANT SHALL PAY  
20 \$1,000.00 FOR A CERTIFICATE OF NEED APPLICATION THAT RECEIVES  
21 EXPEDITED PROCESSING AT THE REQUEST OF THE APPLICANT.

22 (D) THE DEPARTMENT SHALL CHARGE A FEE OF \$500.00 TO REVIEW  
23 ANY LETTER OF INTENT REQUESTING OR RESULTING IN A WAIVER FROM  
24 CERTIFICATE OF NEED REVIEW AND ANY AMENDMENT REQUEST TO AN  
25 APPROVED CERTIFICATE OF NEED.

26 (E) A HEALTH FACILITY OR AGENCY THAT OFFERS CERTIFICATE OF  
27 NEED COVERED CLINICAL SERVICES SHALL PAY \$100.00 FOR EACH



1 CERTIFICATE OF NEED APPROVED COVERED CLINICAL SERVICE AS PART OF  
2 THE CERTIFICATE OF NEED ANNUAL SURVEY AT THE TIME OF SUBMISSION  
3 OF THE SURVEY DATA.

4 (F) The department of community health shall use the fees  
5 collected under this subsection only to fund the certificate of  
6 need program. Funds remaining in the certificate of need program  
7 at the end of the fiscal year shall not lapse to the general fund  
8 but shall remain available to fund the certificate of need  
9 program in subsequent years.

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

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

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

25 (7) The department may charge a fee to recover the cost of  
26 purchase or production and distribution of proficiency evaluation  
27 samples that are supplied to clinical laboratories ~~pursuant to~~

1 **UNDER** section 20521(3).

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

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

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

15 (11) An applicant for licensure or renewal of licensure  
16 under part 209 shall pay the applicable fees set forth in part  
17 209.

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

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



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

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



1 (c) Within 30 days after September 30, 2005, the department  
2 shall submit an application to the federal centers for medicare  
3 and medicaid services to request a waiver pursuant to 42 CFR  
4 433.68(e) to implement this subdivision as follows:

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



1 quarterly basis, the first payment due 90 days after the date the  
2 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  
6 to 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  
11 state's medicaid plan. As used in this subparagraph, "continuing  
12 care retirement center" means a nursing care facility that  
13 provides independent living services, assisted living services,  
14 and nursing care and medical treatment services, in a campus-like  
15 setting that has shared facilities or common areas, or both.

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

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

27 (f) If a nursing home or a hospital long-term care unit



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

9 (g) The medicaid nursing home quality assurance assessment  
10 fund is established in the state treasury. The department of  
11 community health shall deposit the revenue raised through the  
12 quality assurance assessment with the state treasurer for deposit  
13 in the medicaid nursing home quality assurance assessment fund.

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

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

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

27 (k) The state retention amount of the quality assurance

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

10 (l) Beginning October 1, 2015, the department shall no longer  
11 assess or collect the quality assurance assessment or apply for  
12 federal matching funds. The quality assurance assessment  
13 collected under subsection (1)(g) shall no longer be assessed or  
14 collected after September 30, 2011, in the event that the quality  
15 assurance assessment is not eligible for federal matching funds.  
16 Any portion of the quality assurance assessment collected from a  
17 nursing home or hospital long-term care unit that is not eligible  
18 for federal matching funds shall be returned to the nursing home  
19 or hospital long-term care unit.

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

25 (a) To maintain the increased medicaid reimbursement rate  
26 increases as provided for in subdivision (c).

27 (b) The quality assurance assessment shall be assessed on



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

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

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

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

26 (f) The hospital quality assurance assessment fund is  
27 established in the state treasury. The department of community



1 health shall deposit the revenue raised through the quality  
2 assurance assessment with the state treasurer for deposit in the  
3 hospital quality assurance assessment fund.

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

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

19 (i) The state retention amount of the quality assurance  
20 assessment collected pursuant to subsection (1)(h) shall be equal  
21 to 13.2% of the federal funds generated by the hospital quality  
22 assurance assessment, including the state retention amount. The  
23 state retention percentage shall be applied proportionately to  
24 each hospital quality assurance assessment program to determine  
25 the retention amount for each program. The state retention amount  
26 shall be appropriated each fiscal year to the department of  
27 community health to support medicaid expenditures for hospital



1 services and therapy. These funds shall offset an identical  
2 amount of general fund/general purpose revenue originally  
3 appropriated for that purpose.

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

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

9 Enacting section 1. This amendatory act takes effect October  
10 1, 2013.