

**SENATE SUBSTITUTE FOR
HOUSE BILL NO. 5004**

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
2 special health care needs" or "child" means a single or married
3 individual under ~~21~~**26** years of age whose activity is or may become
4 so restricted by disease or specified medical condition as to
5 reduce the individual's normal capacity for education and self-



1 support.

2 (2) In addition, article 1 contains general definitions and
3 principles of construction applicable to all articles in this code
4 and part 51 contains definitions applicable to this part.

5 Sec. 6237. Until October 1, ~~2023~~, **2027**, the department shall
6 assess a \$500.00 fee for licenses on an annual basis upon
7 determining that the applicant has complied with this part and
8 rules promulgated under this part. A licensee shall prominently
9 display the license while it is in effect.

10 Sec. 13522. (1) In promulgating rules ~~pursuant to~~ **under** this
11 part, the department shall avoid requiring dual licensing, insofar
12 as practical. Rules promulgated by the department may provide for
13 **the** recognition of other state or federal licenses as the
14 department considers desirable, subject to registration
15 requirements prescribed by the department. A person ~~who,~~ **that**, on
16 the effective date of an agreement under ~~Act No. 54 of the Public~~
17 ~~Acts of 1965, being sections 3.801 to 3.802 of the Michigan~~
18 ~~Compiled Laws, 1965 PA 54, MCL 3.801 to 3.802~~, possesses a license
19 issued by the federal government for a source of ionizing radiation
20 of the type for which the state assumes regulatory responsibility
21 under the agreement, is considered to possess an identical license
22 issued ~~pursuant to~~ **under** this part, which license expires either 90
23 days after receipt of a written notice of termination from the
24 department or on the date of expiration stated in the federal
25 license, whichever occurs first.

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



1 (3) Except as otherwise provided in this subsection, the
2 department may promulgate rules to establish a schedule of fees to
3 be paid by an applicant for a license for other sources of ionizing
4 radiation and the renewal of the license, and by a person
5 possessing sources of ionizing radiation that are subject to
6 registration. The registration or registration renewal fee for a
7 radiation machine registered under this part is ~~\$45.00~~**\$104.88** for
8 the first veterinary or dental x-ray or electron tube and ~~\$25.00~~
9 **\$58.19** for each additional veterinary or dental x-ray or electron
10 tube annually, or ~~\$75.00~~**\$174.88** annually per nonveterinary or
11 nondental x-ray or electron tube. The department shall not assess a
12 fee for the amendment of a radiation machine registration
13 certificate. In addition, the department shall assess a fee of
14 ~~\$100.00~~**\$233.23** for each follow-up inspection due to noncompliance
15 during the same year. The department may accept a written
16 certification from the licensee or registrant that the items of
17 noncompliance have been corrected instead of performing a follow-up
18 inspection. If the department does not inspect a source of ionizing
19 radiation for a period of 5 consecutive years, the licensee or
20 registrant of the source of ionizing radiation does not have to pay
21 further license or registration fees as to that source of ionizing
22 radiation until the first license or registration renewal date
23 following the time an inspection of the source of ionizing
24 radiation is made.

25 (4) A fee collected under this part ~~shall~~**must** be deposited in
26 the state treasury and credited to the general fund of this state.

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



1 (a) Inspection, per radiation
2 machine..... \$ 100.00~~233.23~~

3 (b) Reinspection for reinstatement of
4 mammography authorization, per radiation
5 machine..... \$ 100.00~~233.23~~

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

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

14 (6) If an applicant for mammography authorization submits an
15 evaluation report issued by the American ~~college of radiology~~
16 **College of Radiology** that evidences compliance with section
17 13523(2) (a), the department shall waive the fee under subsection
18 (5) for department evaluation of compliance with that provision.

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

21 (8) The department shall adjust on an annual basis the fees
22 prescribed by subsections (3) and (5) by an amount determined by
23 the state treasurer to reflect the cumulative annual percentage
24 change in the Detroit ~~consumer price index~~, **Consumer Price Index**,
25 not to exceed 5%. As used in this subsection, "Detroit ~~consumer~~
26 ~~price index~~" **Consumer Price Index**" means the most comprehensive
27 index of consumer prices available for the Detroit area from the
28 ~~bureau of labor statistics~~ **Bureau of Labor Statistics** of the United
29 States ~~department of labor~~. **Department of Labor**.



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 1395III.

(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 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.

(b) In addition to the fees under subdivision (a), the



1 applicant shall pay \$3,000.00 for any designated complex project
2 including a project scheduled for comparative review or for a
3 consolidated licensed health facility application for acquisition
4 or replacement.

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

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

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

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

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

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



1 fees paid to the department.

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

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

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

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

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

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

27 (a) The quality assurance assessment and all federal matching
28 funds attributed to that assessment must be used to finance
29 Medicaid nursing home reimbursement payments. Only licensed nursing



1 homes and hospital long-term care units that are assessed the
2 quality assurance assessment and participate in the Medicaid
3 program are eligible for increased per diem Medicaid reimbursement
4 rates under this subdivision. A nursing home or long-term care unit
5 that is assessed the quality assurance assessment and that does not
6 pay the assessment required under subsection (1)(g) in accordance
7 with subdivision (c)(i) or in accordance with a written payment
8 agreement with this state shall not receive the increased per diem
9 Medicaid reimbursement rates under this subdivision until all of
10 its outstanding quality assurance assessments and any penalties
11 assessed under subdivision (f) have been paid in full. This
12 subdivision does not authorize or require the department to
13 overspend tax revenue in violation of the management and budget
14 act, 1984 PA 431, MCL 18.1101 to 18.1594.

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

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

28 (i) If the waiver is approved, the quality assurance assessment
29 rate for a nursing home or hospital long-term care unit with less



1 than 40 licensed beds or with the maximum number, or more than the
2 maximum number, of licensed beds necessary to secure federal
3 approval of the application is \$2.00 per non-Medicare patient day
4 of care provided within the immediately preceding year or a rate as
5 otherwise altered on the application for the waiver to obtain
6 federal approval. If the waiver is approved, for all other nursing
7 homes and long-term care units the quality assurance assessment
8 rate is to be calculated by dividing the total statewide maximum
9 allowable assessment permitted under subsection (1)(g) less the
10 total amount to be paid by the nursing homes and long-term care
11 units with less than 40 licensed beds or with the maximum number,
12 or more than the maximum number, of licensed beds necessary to
13 secure federal approval of the application by the total number of
14 non-Medicare patient days of care provided within the immediately
15 preceding year by those nursing homes and long-term care units with
16 more than 39 licensed beds, but less than the maximum number of
17 licensed beds necessary to secure federal approval. The quality
18 assurance assessment, as provided under this subparagraph, must be
19 assessed in the first quarter after federal approval of the waiver
20 and must be subsequently assessed on October 1 of each following
21 year, and is payable on a quarterly basis, with the first payment
22 due 90 days after the date the assessment is assessed.

23 (ii) If the waiver is approved, continuing care retirement
24 centers are exempt from the quality assurance assessment if the
25 continuing care retirement center requires each center resident to
26 provide an initial life interest payment of \$150,000.00, on
27 average, per resident to ensure payment for that resident's
28 residency and services and the continuing care retirement center
29 utilizes all of the initial life interest payment before the



1 resident becomes eligible for medical assistance under the state's
2 Medicaid plan. As used in this subparagraph, "continuing care
3 retirement center" means a nursing care facility that provides
4 independent living services, assisted living services, and nursing
5 care and medical treatment services, in a campus-like setting that
6 has shared facilities or common areas, or both.

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

13 (e) 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 (f) If a nursing home or a hospital long-term care unit fails
18 to pay the assessment required by subsection (1)(g), the department
19 may assess the nursing home or hospital long-term care unit a
20 penalty of 5% of the assessment for each month that the assessment
21 and penalty are not paid up to a maximum of 50% of the assessment.
22 The department may also refer for collection to the department of
23 treasury past due amounts consistent with section 13 of 1941 PA
24 122, MCL 205.13.

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



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

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

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

14 (k) The state retention amount of the quality assurance
15 assessment collected under subsection (1)(g) must be equal to 13.2%
16 of the federal funds generated by the nursing homes and hospital
17 long-term care units quality assurance assessment, including the
18 state retention amount. The state retention amount must be
19 appropriated each fiscal year to the department to support Medicaid
20 expenditures for long-term care services. These funds must offset
21 an identical amount of general fund/general purpose revenue
22 originally appropriated for that purpose.

23 (l) Beginning October 1, ~~2023~~, **2027**, the department shall not
24 assess or collect the quality assurance assessment or apply for
25 federal matching funds. The quality assurance assessment collected
26 under subsection (1)(g) must not be assessed or collected after
27 September 30, 2011 if the quality assurance assessment is not
28 eligible for federal matching funds. Any portion of the quality
29 assurance assessment collected from a nursing home or hospital



1 long-term care unit that is not eligible for federal matching funds
2 must be returned to the nursing home or hospital long-term care
3 unit.

4 (12) The quality assurance dedication is an earmarked
5 assessment collected under subsection (1)(h). That assessment and
6 all federal matching funds attributed to that assessment must be
7 used only for the following purpose and under the following
8 specific circumstances:

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

11 (b) The quality assurance assessment must be assessed on all
12 net patient revenue, before deduction of expenses, less Medicare
13 net revenue, as reported in the most recently available Medicare
14 cost report and is payable on a quarterly basis, with the first
15 payment due 90 days after the date the assessment is assessed. As
16 used in this subdivision, "Medicare net revenue" includes Medicare
17 payments and amounts collected for coinsurance and deductibles.

18 (c) Beginning October 1, 2002, the department shall increase
19 the hospital Medicaid reimbursement rates for the balance of that
20 year. For each subsequent year in which the quality assurance
21 assessment is assessed and collected, the department shall maintain
22 the hospital Medicaid reimbursement rate increase financed by the
23 quality assurance assessments.

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

28 (e) If a hospital fails to pay the assessment required by
29 subsection (1)(h), the department may assess the hospital a penalty



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

6 (f) The hospital quality assurance assessment fund is
7 established in the state treasury. The department shall deposit the
8 revenue raised through the quality assurance assessment with the
9 state treasurer for deposit in the hospital quality assurance
10 assessment fund.

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

19 (h) The quality assurance assessment collected under
20 subsection (1) (h) must not be assessed or collected after September
21 30, 2011 if the quality assurance assessment is not eligible for
22 federal matching funds. Any portion of the quality assurance
23 assessment collected from a hospital that is not eligible for
24 federal matching funds must be returned to the hospital.

25 (i) The state retention amount of the quality assurance
26 assessment collected under subsection (1) (h) must be equal to 13.2%
27 of the federal funds generated by the hospital quality assurance
28 assessment, including the state retention amount. The 13.2% state
29 retention amount described in this subdivision does not apply to



1 the Healthy Michigan plan. ~~In the fiscal year ending September 30,~~
 2 ~~2016, there is a 1-time additional retention amount of up to~~
 3 ~~\$92,856,100.00. In the fiscal year ending September 30, 2017, there~~
 4 ~~is a retention amount of \$105,000,000.00 for the Healthy Michigan~~
 5 ~~plan. Beginning in the fiscal year ending September 30, 2018, and~~
 6 ~~for each fiscal year thereafter, there is a retention amount of at~~
 7 ~~least \$118,420,600.00 for each fiscal year for the Healthy Michigan~~
 8 ~~plan. **By May 31 of each year, the department, the state budget**~~
 9 ~~**office, and the Michigan Health and Hospital Association shall**~~
 10 ~~**identify an appropriate retention amount for the Healthy Michigan**~~
 11 ~~**plan.**~~ The state retention percentage must be applied
 12 proportionately to each hospital quality assurance assessment
 13 program to determine the retention amount for each program. The
 14 state retention amount must be appropriated each fiscal year to the
 15 department to support Medicaid expenditures for hospital services
 16 and therapy. These funds must offset an identical amount of general
 17 fund/general purpose revenue originally appropriated for that
 18 purpose. ~~By May 31, 2019, the department, the state budget office,~~
 19 ~~and the Michigan Health and Hospital Association shall identify an~~
 20 ~~appropriate retention amount for the fiscal year ending September~~
 21 ~~30, 2020 and each fiscal year thereafter.~~

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

24 (a) The quality assurance assessment authorized under this
 25 subsection must be used to provide reimbursement to Medicaid
 26 ambulance providers. The department may promulgate rules to provide
 27 the structure of the quality assurance assessment authorized under
 28 this subsection and the level of the assessment.

29 (b) The department shall implement this subsection in a manner



1 that complies with federal requirements necessary to ensure that
 2 the quality assurance assessment qualifies for federal matching
 3 funds.

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

6 (d) The quality assurance assessment authorized under this
 7 subsection must not be collected after October 1, ~~2023.~~**2027**. The
 8 quality assurance assessment authorized under this subsection must
 9 no longer be collected or assessed if the quality assurance
 10 assessment authorized under this subsection is not eligible for
 11 federal matching funds.

12 (e) ~~Beginning November 1, 2020, and by~~ **By** November 1 of each
 13 year, ~~thereafter,~~ the department shall send a notification to each
 14 ambulance operation that will be assessed the quality assurance
 15 assessment authorized under this subsection during the year in
 16 which the notification is sent.

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

19 ~~(15) For the fiscal year ending September 30, 2020 only,~~
 20 ~~\$3,000,000.00 of the money in the certificate of need program is~~
 21 ~~transferred to and must be deposited into the general fund.~~

22 **(15)** ~~(16)~~ As used in this section:

23 (a) "Healthy Michigan plan" means the medical assistance
 24 program described in section 105d of the social welfare act, 1939
 25 PA 280, MCL 400.105d, that has a federal matching fund rate of not
 26 less than 90%.

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

