HOUSE BILL NO. 6364

September 07, 2022, Introduced by Rep. Lightner and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 20106, 20109, and 20161 (MCL 333.20106, 333.20109, and 333.20161), section 20106 as amended by 2017 PA 167, section 20109 as amended by 2015 PA 156, and section 20161 as amended by 2020 PA 169, and by adding part 219A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 20106. (1) "Health facility or agency", except as provided in section 20115, means:

(a) An ambulance operation, aircraft transport operation, nontransport prehospital life support operation, or medical first response service.

(b) A county medical care facility.

(c) A freestanding surgical outpatient facility.

(d) A health maintenance organization.

(e) A home for the aged.

(f) A hospital.

(g) A nursing home.

(h) A hospice.

(i) A hospice residence.

(j) A facility or agency listed in subdivisions (a) to (g) located in a university, college, or other educational institution.

(k) A supplemental nursing services agency.

(2) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.

(3) "Home for the aged" means a supervised personal care facility at a single address, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility that provides room, board, and supervised personal care to 21 or more unrelated, nontransient, individuals 55 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 55 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home. Home for the aged does not include an area excluded from this definition by section 17(3) of the continuing care community disclosure act, 2014 PA 448, MCL 554.917.

(4) "Hospice" means a health care program that provides a

coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(5) "Hospital" means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. Hospital does not include a mental health hospital licensed or operated by the department of health and human services or a hospital operated by the department of corrections.

(6) "Hospital long-term care unit" means a nursing care facility, owned and operated by and as part of a hospital, providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

Sec. 20109. (1) "Nursing home" means a nursing care facility, including a county medical care facility, that provides organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity. As used in this subsection, "medical treatment" includes treatment by an employee or independent contractor of the nursing home who is an individual licensed or otherwise authorized to engage in a health profession under part 170 or 175. Nursing home does not include any of the following:

(a) A unit in a state correctional facility.

(b) A hospital.

(c) A veterans facility created under **former** 1885 PA 152. ~~, MCL 36.1 to 36.12.~~

(d) A hospice residence that is licensed under this article.

(e) A hospice that is certified under 42 CFR 418.100.

(2) "Person" means that term as defined in section 1106 or a governmental entity.

(3) "Public member" means a member of the general public who is not a provider; who does not have an ownership interest in or contractual relationship with a nursing home other than a resident contract; who does not have a contractual relationship with a person who does substantial business with a nursing home; and who is not the spouse, parent, sibling, or child of an individual who has an ownership interest in or contractual relationship with a nursing home, other than a resident contract.

(4) "Skilled nursing facility" means a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or a distinct part thereof, certified by the department to provide skilled nursing care.

(5) "Supplemental nursing services agency" means a person that is engaged for hire in the business of providing or procuring temporary employment in a health facility or agency for a nurse, nursing assistant, nurse aide, or orderly. Supplemental nursing services agency does not include either of the following:

(a) A person that provides staff to a home health agency as that term is defined in section 20173a.

(b) An individual if the individual is a nurse, nursing assistant, nurse aide, or orderly and provides the individual's services as a nurse, nursing assistant, nurse aide, or orderly on a temporary basis to a health facility or agency.

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. Until October 1, 2023, except as otherwise provided in this article, fees and assessments must be paid as provided in the following schedule:

(a) Freestanding surgical outpatient facilities.....	$500.00 per facility license.
(b) Hospitals.....	$500.00 per facility license and $10.00 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units....	$500.00 per facility license and $3.00 per licensed bed over 100 licensed beds.
(d) Homes for the aged.....	$6.27 per licensed bed.
(e) Hospice agencies.....	$500.00 per agency license.
(f) Hospice residences.....	$500.00 per facility license and $5.00 per licensed bed.
(g) Subject to subsection (11), 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 (12), 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 (12)(a) and (i).
(i) Initial licensure application fee for subdivisions (a), (b), (c), (e), ~~and~~ (f), **and (j)**	$2,000.00 per initial license.
(j) Supplemental nursing services agencies.....	**$2,000.00 per agency 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, "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.

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

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

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

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

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

(f) Except as otherwise provided in this section, the department 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 do not lapse to the general fund but remain available to fund the certificate of need program in subsequent years.

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

(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 cost of licensure activities must be supported by license fees.

(8) 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 must 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.

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

(10) Except as otherwise provided in this section, the fees and assessments collected under this section must 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.

(11) The quality assurance assessment collected under subsection (1)(g) and all federal matching funds attributed to that assessment must 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 must 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 this 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 under subdivision (f) have been paid in full. This subdivision does not 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 non-Medicare patients within the immediately preceding year, must 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, with 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 according 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 non-Medicare 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 licensed beds 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 non-Medicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39 licensed beds, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, must be assessed in the first quarter after federal approval of the waiver and must be subsequently assessed on October 1 of each following year, and is payable on a quarterly basis, with 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 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 shall maintain the Medicaid nursing home reimbursement payment increase financed by the quality assurance assessment.

(e) The department shall implement this section in a manner that complies with federal requirements necessary to ensure 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 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 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 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 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) must 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 must 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 under subsection (1)(g) must 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 must be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2023, the department shall not assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection (1)(g) must not be assessed or collected after September 30, 2011 if 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 must be returned to the nursing home or hospital long-term care unit.

(12) The quality assurance dedication is an earmarked assessment collected under subsection (1)(h). That assessment and all federal matching funds attributed to that assessment must 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 must 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, with 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 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 shall maintain the hospital Medicaid reimbursement rate increase financed by the quality assurance assessments.

(d) The department shall implement this section in a manner that complies with federal requirements necessary to ensure 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 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 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 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 must 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) must not be assessed or collected after September 30, 2011 if 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 must be returned to the hospital.

(i) The state retention amount of the quality assurance assessment collected under subsection (1)(h) must be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The 13.2% state retention amount described in this subdivision does not apply to the Healthy Michigan plan. In the fiscal year ending September 30,

2016, there is a 1-time additional retention amount of up to $92,856,100.00. In the fiscal year ending September 30, 2017, there is a retention amount of $105,000,000.00 for the Healthy Michigan plan. Beginning in the fiscal year ending September 30, 2018, and for each fiscal year thereafter, there is a retention amount of $118,420,600.00 for each fiscal year for the Healthy Michigan plan. The state retention percentage must be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose. By May 31, 2019, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount for the fiscal year ending September 30, 2020 and each fiscal year thereafter.

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

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

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

(c) The total annual collections by the department under this

subsection must not exceed $20,000,000.00.

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

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

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

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

(16) As used in this section:

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

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

PART 219A

SUPPLEMENTAL NURSING SERVICES AGENCIES

Sec. 21951. (1) As used in this part:

(a) "Nurse" means an individual who is licensed or otherwise authorized to engage in the practice of nursing or practice of nursing as a licensed practical nurse under part 172.

(b) "Nurse aide" means an individual who holds an authorization under part 219 to practice as a nurse aide under the nurse aide training and registration program described in section 21907.

(2) In addition, article 1 contains general definitions and principles of construction applicable to all articles in this code and part 201 contains definitions applicable to this part.

Sec. 21953. (1) A supplemental nursing services agency must be licensed under this article.

(2) "Supplemental nursing services agency" or a similar term or abbreviation must not be used to describe or refer to a supplemental nursing services agency unless it is licensed under this article.

Sec. 21955. (1) In addition to any information required under section 20142, a person shall include, as part of its application for licensure as a supplemental nursing services agency, all of the following:

(a) The names, addresses, principal occupations, and official position of all persons who have an ownership interest in the supplemental nursing services agency.

(b) A policy or procedure describing how the supplemental nursing services agency's records will be immediately available at all times to the department.

(c) Proof satisfactory to the department that the supplemental nursing services agency complies with all of the following:

(*i*) The supplemental nursing services agency documents that each nurse, nursing assistant, nurse aide, or orderly provided to a health facility or agency on a temporary basis by the supplemental nursing services agency meets the minimum licensing, training, and

continuing education standards for the position in which the nurse, nursing assistant, nurse aide, or orderly will be working.

(*ii*) The supplemental nursing services agency ensures that each nurse, nursing assistant, nurse aide, or orderly provided to a health facility or agency on a temporary basis by the supplemental nursing services agency meets the qualifications of personnel employed in the health facility or agency in which the nurse, nursing assistant, nurse aide, or orderly is placed.

(*iii*) The supplemental nursing services agency demonstrates to the satisfaction of the department that each nurse, nursing assistant, nurse aide, and orderly provided to a health facility or agency by the supplemental nursing services agency is an employee of the supplemental nursing services agency.

(*iv*) The supplemental nursing services agency does not restrict the employment opportunities of a nurse, nursing assistant, nurse aide, or orderly who is employed by the supplemental nursing services agency.

(*v*) The supplemental nursing services agency does not, in a contract with a nurse, nursing assistant, nurse aide, or orderly, or a contract with a health facility or agency, require the payment of damages, employment fees, or other compensation if the nurse, nursing assistant, nurse aide, or orderly is hired by the health facility or agency.

(*vi*) The requirements described in section 1003(2)(c) of the occupational code, 1980 PA 299, MCL 339.1003.

(2) A supplemental nursing services agency shall retain any records or documentation described in this section for the granting of a license for not less than 5 years after the date the license is granted by the department and shall make the records and

documentation available to the department on the department's request.

(3) The owner, operator, and governing body of a supplemental nursing services agency licensed under this article shall cooperate with the department in the enforcement of this part.

Sec. 21957. (1) Subject to subsection (2), a supplemental nursing services agency shall not bill, or receive a payment from, a health facility or agency at a rate that is higher than 25% of the hourly wage rate paid to a nurse, nursing assistant, nurse aide, or orderly who is provided to the health facility or agency on a temporary basis by the supplemental nursing services agency.

(2) A health facility or agency that pays for the actual travel and housing costs for a nurse, nursing assistant, nurse aide, or orderly described in subsection (1) and that pays the costs described in this subsection to any of the following is not violating the limitation on charges described in this section:

(a) The nurse, nursing assistant, nurse aide, or orderly.

(b) The supplemental nursing services agency that provided the nurse, nursing assistant, nurse aide, or orderly to the health facility or agency on a temporary basis.