HOUSE BILL NO. 5478

October 21, 2021, Introduced by Reps. Wozniak, Bezotte and Green and referred to the Committee on Regulatory Reform.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 20106, 20109, 20115, and 20161 (MCL 333.20106, 333.20109, 333.20115, and 333.20161), section 20106 as amended by 2017 PA 167, section 20109 as amended by 2015 PA 156, section 20115 as amended by 2012 PA 499, and section 20161 as amended by 2020 PA 169, and by adding part 211.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 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 recovery care center.

(d) ~~(c)~~ A freestanding surgical outpatient facility.

(e) ~~(d)~~ A health maintenance organization.

(f) ~~(e)~~ A home for the aged.

(g) ~~(f)~~ A hospital.

(h) ~~(g)~~ A nursing home.

(i) ~~(h)~~ A hospice.

(j) ~~(i)~~ A hospice residence.

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

(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

1 community disclosure act, 2014 PA 448, MCL 554.917.
2 (4) "Hospice" means a health care program that provides a
3 coordinated set of services rendered at home or in outpatient or
4 institutional settings for individuals suffering from a disease or
5 condition with a terminal prognosis.
6 (5) "Hospital" means a facility offering inpatient, overnight
7 care, and services for observation, diagnosis, and active treatment
8 of an individual with a medical, surgical, obstetric, chronic, or
9 rehabilitative condition requiring the daily direction or
10 supervision of a physician. Hospital does not include a mental
11 health hospital licensed or operated by the department of health
12 and human services or a hospital operated by the department of
13 corrections.
14 (6) "Hospital long-term care unit" means a nursing care
15 facility, owned and operated by and as part of a hospital,
16 providing organized nursing care and medical treatment to 7 or more
17 unrelated individuals suffering or recovering from illness, injury,
18 or infirmity.
19 Sec. 20109. (1) "Nursing home" means a nursing care facility,
20 including a county medical care facility, that provides organized
21 nursing care and medical treatment to 7 or more unrelated
22 individuals suffering or recovering from illness, injury, or
23 infirmity. As used in this subsection, "medical treatment" includes
24 treatment by an employee or independent contractor of the nursing
25 home who is an individual licensed or otherwise authorized to
26 engage in a health profession under part 170 or 175. Nursing home
27 does not include any of the following:
28 (a) A unit in a state correctional facility.
29 (b) A hospital.

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

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

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

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

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

15 **(4) "Recovery care center" means a facility that provides**
16 **postsurgical and postdiagnostic medical and nursing services to a**
17 **patient who is recovering from a surgical procedure performed in a**
18 **freestanding surgical outpatient facility.**

19 **(5)** ~~(4)~~ "Skilled nursing facility" means a hospital long-term
20 care unit, nursing home, county medical care facility, or other
21 nursing care facility, or a distinct part thereof, certified by the
22 department to provide skilled nursing care.

23 Sec. 20115. (1) The department may promulgate rules to further
24 define the term "health facility or agency" and the definition of a
25 health facility or agency listed in section 20106 as required to
26 implement this article. The department may define a specific
27 organization as a health facility or agency for the sole purpose of
28 certification authorized under this article. For purpose of
29 certification only, an organization defined in section 20106(5),

1 20108(1), or ~~20109(4)~~ **20109(5)** is considered a health facility or
2 agency. The term "health facility or agency" does not mean a
3 visiting nurse service or home aide service conducted by and for
4 the adherents of a church or religious denomination for the purpose
5 of providing service for those who depend upon spiritual means
6 through prayer alone for healing.
7 (2) The department shall promulgate rules to differentiate a
8 freestanding surgical outpatient facility from a private office of
9 a physician, dentist, podiatrist, or other health professional. The
10 department shall specify in the rules that a facility including,
11 but not limited to, a private practice office described in this
12 subsection must be licensed under this article as a freestanding
13 surgical outpatient facility if that facility performs 120 or more
14 surgical abortions per year and publicly advertises outpatient
15 abortion services.
16 (3) The department shall promulgate rules that ~~in effect~~
17 ~~republish R 325.3826, R 325.3832, R 325.3835, R 325.3857, R~~
18 ~~325.3866, R 325.3867, and R 325.3868 of the Michigan administrative~~
19 ~~code, but shall~~ include ~~in the rules~~ standards for a freestanding
20 surgical outpatient facility or private practice office that
21 performs 120 or more surgical abortions per year and that publicly
22 advertises outpatient abortion services. The department shall
23 ~~assure~~ **ensure** that the standards are consistent with the most
24 recent United States ~~supreme court~~ **Supreme Court** decisions
25 regarding state regulation of abortions.
26 (4) Subject to section 20145 and part 222, the department may
27 modify or waive 1 or more ~~of the~~ rules contained in ~~R 325.3801 to R~~
28 ~~325.3877 of~~ the Michigan ~~administrative code~~ **Administrative Code**
29 regarding construction or equipment standards, or both, for a

freestanding surgical outpatient facility that performs 120 or more surgical abortions per year and that publicly advertises outpatient abortion services, if both of the following conditions are met:

(a) The freestanding surgical outpatient facility was in existence and operating on December 31, 2012.

(b) The department makes a determination that the existing construction or equipment conditions, or both, within the freestanding surgical outpatient facility are adequate to preserve the health and safety of the patients and employees of the freestanding surgical outpatient facility or that the construction or equipment conditions, or both, can be modified to adequately preserve the health and safety of the patients and employees of the freestanding surgical outpatient facility without meeting the specific requirements of the rules.

(5) By January 15 each year, the department of ~~community~~ health **and human services** shall provide the following information to the department: ~~of licensing and regulatory affairs:~~

(a) From data received by the department of ~~community~~ health **and human services** through the abortion reporting requirements of section 2835, all of the following:

(*i*) The name and location of each facility at which abortions were performed during the immediately preceding calendar year.

(*ii*) The total number of abortions performed at that facility location during the immediately preceding calendar year.

(*iii*) The total number of surgical abortions performed at that facility location during the immediately preceding calendar year.

(b) Whether a facility at which surgical abortions were performed in the immediately preceding calendar year publicly advertises abortion services.

1 (6) As used in this section:
2 (a) "Abortion" means that term as defined in section 17015.
3 (b) "Publicly advertises" means to advertise using directory
4 or internet advertising including yellow pages, white pages, banner
5 advertising, or electronic publishing.
6 (c) "Surgical abortion" means an abortion that is not a
7 medical abortion as that term is defined in section 17017.
8 Sec. 20161. (1) The department shall assess fees and other
9 assessments for health facility and agency licenses and
10 certificates of need on an annual basis as provided in this
11 article. Until October 1, 2023, except as otherwise provided in
12 this article, fees and assessments must be paid as provided in the
13 following schedule:
14 (a) Freestanding surgical
15 outpatient facilities..............$500.00 per facility license.
16 **(b) Recovery care centers... $500.00 per facility license.**
17 **(c)** ~~(b)~~ Hospitals $500.00 per facility license and
18 .... $10.00 per licensed bed.
19 **(d)** ~~(c)~~ Nursing homes, county
20 medical care facilities, and
21 hospital long-term care units .....$500.00 per facility license and
22 $3.00 per licensed bed over 100
23 licensed beds.
24 **(e)** ~~(d)~~ Homes for the aged
25 ...... $6.27 per licensed bed.
26 **(f)** ~~(e)~~ Hospice agencies
27 .... $500.00 per agency license.
28 **(g)** ~~(f)~~ Hospice residences $500.00 per facility license and
29 ...... $5.00 per licensed bed.

(h) ~~(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.

(i) ~~(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).

(j) ~~(i)~~ Initial licensure application fee for subdivisions (a), (b), (c), ~~(e), and~~ **(d)**, (f), **and (g)** .... $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, "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,

1 an additional fee of $5,000.00 is added to the base fee. For a
2 project requiring a projected capital expenditure of $4,000,000.00
3 or more but less than $10,000,000.00, an additional fee of
4 $8,000.00 is added to the base fee. For a project requiring a
5 projected capital expenditure of $10,000,000.00 or more, an
6 additional fee of $12,000.00 is added to the base fee.
7 (b) In addition to the fees under subdivision (a), the
8 applicant shall pay $3,000.00 for any designated complex project
9 including a project scheduled for comparative review or for a
10 consolidated licensed health facility application for acquisition
11 or replacement.
12 (c) If required by the department, the applicant shall pay
13 $1,000.00 for a certificate of need application that receives
14 expedited processing at the request of the applicant.
15 (d) The department shall charge a fee of $500.00 to review any
16 letter of intent requesting or resulting in a waiver from
17 certificate of need review and any amendment request to an approved
18 certificate of need.
19 (e) A health facility or agency that offers certificate of
20 need covered clinical services shall pay $100.00 for each
21 certificate of need approved covered clinical service as part of
22 the certificate of need annual survey at the time of submission of
23 the survey data.
24 (f) Except as otherwise provided in this section, the
25 department shall use the fees collected under this subsection only
26 to fund the certificate of need program. Funds remaining in the
27 certificate of need program at the end of the fiscal year do not
28 lapse to the general fund but remain available to fund the
29 certificate of need program in subsequent years.

1 (4) A license issued under this part is effective for no
2 longer than 1 year after the date of issuance.
3 (5) Fees described in this section are payable to the
4 department at the time an application for a license, permit, or
5 certificate is submitted. If an application for a license, permit,
6 or certificate is denied or if a license, permit, or certificate is
7 revoked before its expiration date, the department shall not refund
8 fees paid to the department.
9 (6) The fee for a provisional license or temporary permit is
10 the same as for a license. A license may be issued at the
11 expiration date of a temporary permit without an additional fee for
12 the balance of the period for which the fee was paid if the
13 requirements for licensure are met.
14 (7) The cost of licensure activities must be supported by
15 license fees.
16 (8) The application fee for a waiver under section 21564 is
17 $200.00 plus $40.00 per hour for the professional services and
18 travel expenses directly related to processing the application. The
19 travel expenses must be calculated in accordance with the state
20 standardized travel regulations of the department of technology,
21 management, and budget in effect at the time of the travel.
22 (9) An applicant for licensure or renewal of licensure under
23 part 209 shall pay the applicable fees set forth in part 209.
24 (10) Except as otherwise provided in this section, the fees
25 and assessments collected under this section must be deposited in
26 the state treasury, to the credit of the general fund. The
27 department may use the unreserved fund balance in fees and
28 assessments for the criminal history check program required under
29 this article.

(11) The quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(h)** 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)~~ **(1)(h)** 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)~~ **(1)(h)** 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),~~ **(1)(h)**, 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

1 department of treasury past due amounts consistent with section 13
2 of 1941 PA 122, MCL 205.13.
3 (g) The Medicaid nursing home quality assurance assessment
4 fund is established in the state treasury. The department shall
5 deposit the revenue raised through the quality assurance assessment
6 with the state treasurer for deposit in the Medicaid nursing home
7 quality assurance assessment fund.
8 (h) The department shall not implement this subsection in a
9 manner that conflicts with 42 USC 1396b(w).
10 (i) The quality assurance assessment collected under
11 subsection ~~(1)(g)~~ **(1)(h)** must be prorated on a quarterly basis for
12 any licensed beds added to or subtracted from a nursing home or
13 hospital long-term care unit since the immediately preceding July
14 1. Any adjustments in payments are due on the next quarterly
15 installment due date.
16 (j) In each fiscal year governed by this subsection, Medicaid
17 reimbursement rates must not be reduced below the Medicaid
18 reimbursement rates in effect on April 1, 2002 as a direct result
19 of the quality assurance assessment collected under subsection
20 ~~(1)(g).~~ **(1)(h).**
21 (k) The state retention amount of the quality assurance
22 assessment collected under subsection ~~(1)(g)~~ **(1)(h)** must be equal
23 to 13.2% of the federal funds generated by the nursing homes and
24 hospital long-term care units quality assurance assessment,
25 including the state retention amount. The state retention amount
26 must be appropriated each fiscal year to the department to support
27 Medicaid expenditures for long-term care services. These funds must
28 offset an identical amount of general fund/general purpose revenue
29 originally appropriated for that purpose.

1 (*l*) Beginning October 1, 2023, the department shall not assess
2 or collect the quality assurance assessment or apply for federal
3 matching funds. The quality assurance assessment collected under
4 subsection ~~(1)(g)~~ **(1)(h)** must not be assessed or collected after
5 September 30, 2011 if the quality assurance assessment is not
6 eligible for federal matching funds. Any portion of the quality
7 assurance assessment collected from a nursing home or hospital
8 long-term care unit that is not eligible for federal matching funds
9 must be returned to the nursing home or hospital long-term care
10 unit.
11 (12) The quality assurance dedication is an earmarked
12 assessment collected under subsection ~~(1)(h).~~ **(1)(i).** That
13 assessment and all federal matching funds attributed to that
14 assessment must be used only for the following purpose and under
15 the following specific circumstances:
16 (a) To maintain the increased Medicaid reimbursement rate
17 increases as provided for in subdivision (c).
18 (b) The quality assurance assessment must be assessed on all
19 net patient revenue, before deduction of expenses, less Medicare
20 net revenue, as reported in the most recently available Medicare
21 cost report and is payable on a quarterly basis, with the first
22 payment due 90 days after the date the assessment is assessed. As
23 used in this subdivision, "Medicare net revenue" includes Medicare
24 payments and amounts collected for coinsurance and deductibles.
25 (c) Beginning October 1, 2002, the department shall increase
26 the hospital Medicaid reimbursement rates for the balance of that
27 year. For each subsequent year in which the quality assurance
28 assessment is assessed and collected, the department shall maintain
29 the hospital Medicaid reimbursement rate increase financed by the

1 quality assurance assessments.
2 (d) The department shall implement this section in a manner
3 that complies with federal requirements necessary to ensure that
4 the quality assurance assessment qualifies for federal matching
5 funds.
6 (e) If a hospital fails to pay the assessment required by
7 subsection ~~(1)(h),~~ **(1)(i),** the department may assess the hospital a
8 penalty of 5% of the assessment for each month that the assessment
9 and penalty are not paid up to a maximum of 50% of the assessment.
10 The department may also refer for collection to the department of
11 treasury past due amounts consistent with section 13 of 1941 PA
12 122, MCL 205.13.
13 (f) The hospital quality assurance assessment fund is
14 established in the state treasury. The department shall deposit the
15 revenue raised through the quality assurance assessment with the
16 state treasurer for deposit in the hospital quality assurance
17 assessment fund.
18 (g) In each fiscal year governed by this subsection, the
19 quality assurance assessment must only be collected and expended if
20 Medicaid hospital inpatient DRG and outpatient reimbursement rates
21 and disproportionate share hospital and graduate medical education
22 payments are not below the level of rates and payments in effect on
23 April 1, 2002 as a direct result of the quality assurance
24 assessment collected under subsection ~~(1)(h),~~ **(1)(i),** except as
25 provided in subdivision (h).
26 (h) The quality assurance assessment collected under
27 subsection ~~(1)(h)~~ **(1)(i)** must not be assessed or collected after
28 September 30, 2011 if the quality assurance assessment is not
29 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)~~ **(1)(i)** 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

1 subsection must be used to provide reimbursement to Medicaid
2 ambulance providers. The department may promulgate rules to provide
3 the structure of the quality assurance assessment authorized under
4 this subsection and the level of the assessment.
5 (b) The department shall implement this subsection in a manner
6 that complies with federal requirements necessary to ensure that
7 the quality assurance assessment qualifies for federal matching
8 funds.
9 (c) The total annual collections by the department under this
10 subsection must not exceed $20,000,000.00.
11 (d) The quality assurance assessment authorized under this
12 subsection must not be collected after October 1, 2023. The quality
13 assurance assessment authorized under this subsection must no
14 longer be collected or assessed if the quality assurance assessment
15 authorized under this subsection is not eligible for federal
16 matching funds.
17 (e) Beginning November 1, 2020, and by November 1 of each year
18 thereafter, the department shall send a notification to each
19 ambulance operation that will be assessed the quality assurance
20 assessment authorized under this subsection during the year in
21 which the notification is sent.
22 (14) The quality assurance assessment provided for under this
23 section is a tax that is levied on a health facility or agency.
24 (15) For the fiscal year ending September 30, 2020 only,
25 $3,000,000.00 of the money in the certificate of need program is
26 transferred to and must be deposited into the general fund.
27 (16) As used in this section:
28 (a) "Healthy Michigan plan" means the medical assistance
29 program described in section 105d of the social welfare act, 1939

1 PA 280, MCL 400.105d, that has a federal matching fund rate of not
2 less than 90%.
3 (b) "Medicaid" means that term as defined in section 22207.
4
5 **PART 211**
6 **RECOVERY CARE CENTERS**
7 **Sec. 21101. Article 1 contains general definitions and**
8 **principles of construction applicable to all articles in this code,**
9 **and part 201 contains definitions applicable to this part.**
10 **Sec. 21111. (1) A recovery care center shall be licensed under**
11 **this article.**
12 **(2) "Recovery care center" or a similar term or abbreviation**
13 **must not be used to describe or refer to a health facility or**
14 **agency unless it is licensed by the department under this article.**
15 **Sec. 21113. The owner, operator, and governing body of a**
16 **recovery care center licensed under this article are responsible**
17 **for all phases of the operation of the facility, selection of**
18 **medical staff, and quality of care rendered in the facility and**
19 **shall do all of the following:**
20 **(a) Cooperate with the department in the enforcement of this**
21 **article and require that the physicians and other personnel working**
22 **in the facility and for whom a state license or registration is**
23 **required be currently licensed or registered.**
24 **(b) Ensure that physicians admitted to practice in the**
25 **facility are granted professional privileges consistent with the**
26 **capability of the facility and with the physicians' individual**
27 **training, experience, and other qualifications.**
28 **(c) Ensure that physicians admitted to practice in the**
29 **facility are organized into a medical staff to enable an effective**

1 **review of the professional practices of the facility for the**
2 **purpose of reducing morbidity and mortality and improving the care**
3 **provided in the facility for patients.**
4 **(d) Ensure that the facility does not pay a fee to compensate**
5 **or reimburse a medical referral agency or other person that refers**
6 **or recommends an individual to a facility for any form of medical**
7 **or surgical care or treatment.**
8 **Sec. 21121. (1) At least 50% of the owners, operators, and**
9 **governing body of a recovery care center must be an owner or**
10 **operator or on the governing body of a freestanding surgical**
11 **outpatient facility licensed under this article that is physically**
12 **contiguous with the recovery care center.**
13 **(2) The freestanding surgical outpatient facility described in**
14 **subsection (1) must demonstrate to the department of health and**
15 **human services that it has safe operating procedures in an**
16 **outpatient surgery center setting for no less than 24 consecutive**
17 **months and must meet both of the following requirements:**
18 **(a) It is certified by the Centers for Medicare and Medicaid**
19 **Services as participating in the Ambulatory Surgical Center Quality**
20 **Reporting Program administered by the Centers for Medicare and**
21 **Medicaid Services.**
22 **(b) It holds an accreditation from a national accrediting**
23 **organization approved by the department.**
24 **Sec. 21123. A recovery care center shall comply with all of**
25 **the following:**
26 **(a) Have no more than 5 recovery beds for each surgical room**
27 **within the freestanding surgical outpatient facility described in**
28 **section 21121.**
29 **(b) Be located within 35 miles of an acute care hospital.**

1 **(c) Discharge a patient no later than 72 hours from the time**
2 **the patient is admitted to the recovery care center.**
3 **(d) Have either of the following:**
4 **(*i*) A written agreement with a hospital that is located near**
5 **the recovery care center to provide for the emergency admission of**
6 **postsurgical patients who, for unpredictable reasons, may require**
7 **hospital admission and care.**
8 **(*ii*) All of the physicians in the freestanding surgical**
9 **outpatient facility described in section 21121 performing surgeries**
10 **have admitting privileges at a hospital that is located near the**
11 **recovery care center and has the capabilities to treat patients**
12 **requiring medical care that exceeds the capabilities of the**
13 **recovery care center.**
14 **(e) Conform to all patient safety and facility requirements**
15 **provided by the department by rule.**
16 **(f) Establish all of the following items:**
17 **(*i*) Medical screening criteria.**
18 **(*ii*) Evidence-based surgery guidelines.**
19 **(*iii*) Patient safety standards.**
20 **(g) Use admission criteria that are based only on 1 or more of**
21 **the items listed in subdivision (f).**
22 **(h) Notify a patient with Medicare coverage of the services**
23 **provided by the recovery care center that are not covered by**
24 **Medicare.**
25 **(i) Report information to the department as provided by the**
26 **department by rule, including, but not limited to, all of the**
27 **following:**
28 **(*i*) The types of procedures performed at the freestanding**
29 **surgical outpatient facility described in section 21121 for which**

1 **patients are transferred to the recovery care center for recovery.**

2 **(*ii*) The average duration of patient stays at the recovery care**
3 **center.**

4 **(*iii*) The medical acuity of the patients served by the recovery**
5 **care center.**

6 **(*iv*) The types of payers that reimburse services provided at**
7 **the recovery care center and the percentage of each payer type in**
8 **the total number of payers.**

9 **(*v*) The frequency and cause of patient transfers from the**
10 **recovery care center to a hospital.**