HOUSE BILL No. 5031

September 27, 2017, Introduced by Reps. Hammoud, Sabo, Green, Lucido, Brann, Sowerby, Pagan, Maturen, Wittenberg, Ellison, Noble, Liberati, Chang, Yaroch, Farrington, Lasinski, Geiss, Camilleri and Schor and referred to the Committee on Law and Justice.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 20102, 20106, and 20161 (MCL 333.20102, 333.20106, and 333.20161), section 20102 as amended by 2010 PA 381, section 20106 as amended by 2015 PA 104, and section 20161 as amended by 2016 PA 189, and by adding part 212.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 20102. (1) "Advisory commission" means the health facilities and agencies advisory commission created in section 20121.

(2) "Aircraft transport operation" means that term as defined in section 20902.

(3) "Ambulance operation" means that term as defined in section 20902.

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(4) "ASSISTED LIVING FACILITY" MEANS A HOUSING FACILITY FOR OLDER ADULTS OR PEOPLE WITH DISABILITIES THAT MAY PROVIDE SUPERVISION OR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING, COORDINATION OF SERVICES BY OUTSIDE HEALTH CARE PROVIDERS, AND MONITORING OF RESIDENT ACTIVITIES TO HELP TO ENSURE THEIR HEALTH, SAFETY, AND WELL-BEING.

(5) ~~(4)~~ "Attending physician" means the physician selected by, or assigned to, the patient and who has primary responsibility for the treatment and care of the patient.

(6) ~~(5)~~ "Authorized representative" means the individual designated in writing by the board of directors of the corporation or by the owner or person with legal authority to act on behalf of the company or organization on licensing matters. The authorized representative who is not an owner or licensee shall not sign the original license application or amendments to the application.

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) AN ASSISTED LIVING FACILITY.

(I) ~~(h)~~ A hospice.

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

(K) ~~(j)~~ A facility or agency listed in subdivisions (a) to (g) 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, 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 60 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 60 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~~ **PSYCHIATRIC** hospital licensed or operated by the department of ~~community~~ 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. 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, 2019, except as otherwise provided in this article, fees and assessments shall 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) ASSISTED LIVING FACILITIES..	**$1,000.00 PER FACILITY LICENSE.**
(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~~ (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 of the social security act, 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) 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 shall not lapse to the general fund but shall 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 shall 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 shall 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 shall 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)~~ **(1)(H)** and all federal matching funds attributed to that assessment shall 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 shall 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, shall 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, shall be assessed in the first quarter after federal approval of the waiver and shall 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, **A** continuing care retirement ~~centers are~~ **CENTER IS** 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 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)~~ **(1)(H)** shall 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 shall 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).~~ **(1)(H).**

(k) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(H)** shall 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 shall be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds shall offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2019, 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)~~ **(1)(H)** shall 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 shall 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).~~ **(1)(I).** That assessment and all federal matching funds attributed to that assessment shall 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 shall 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),~~ **(1)(I),** 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 shall 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),~~ **(1)(I),** except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(I)** shall 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 shall be returned to the hospital.

(i) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(I)** shall 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. Beginning in the fiscal year ending September 30, 2017, and for each fiscal year ~~thereafter,~~ **AFTER THAT**, there is a retention amount of $105,000,000.00 for each fiscal year for the Healthy Michigan plan. The state retention percentage shall be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount shall be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds shall 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.~~**AFTER THAT.**

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

(a) The quality assurance assessment authorized under this subsection shall 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 shall not exceed $20,000,000.00.

(d) The quality assurance assessment authorized under this subsection shall not be collected after October 1, 2019. The quality assurance assessment authorized under this subsection shall no longer be collected or assessed if the quality assurance assessment authorized under this subsection is not eligible for federal matching funds.

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

(15) As used in this section:

(a) "Healthy Michigan plan" means the medical assistance plan 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 212. ASSISTED LIVING FACILITIES

SEC. 21201. 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. 21203. (1) BEGINNING 1 YEAR AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS PART, AN ASSISTED LIVING FACILITY MUST BE LICENSED UNDER THIS ARTICLE.

(2) "ASSISTED LIVING FACILITY" OR SIMILAR TERM OR ABBREVIATION SHALL NOT BE USED TO DESCRIBE OR REFER TO A HEALTH FACILITY OR AGENCY UNLESS IT IS LICENSED BY THE DEPARTMENT UNDER THIS ARTICLE.

SEC. 21205. (1) THE OWNER, OPERATOR, AND GOVERNING BODY OF AN ASSISTED LIVING FACILITY ARE RESPONSIBLE FOR ALL PHASES OF THE OPERATION OF THE FACILITY AND SHALL ENSURE THAT THE FACILITY MAINTAINS AN ORGANIZED PROGRAM TO PROVIDE ROOM AND BOARD, PROTECTION, SUPERVISION, ASSISTANCE, AND SUPERVISED PERSONAL CARE FOR ITS RESIDENTS.

(2) THE OWNER, OPERATOR, AND GOVERNING BODY SHALL ENSURE THE AVAILABILITY OF EMERGENCY MEDICAL CARE REQUIRED BY A RESIDENT.

(3) THE OWNER, OPERATOR, OR MEMBER OF THE GOVERNING BODY OF AN ASSISTED LIVING FACILITY AND THE AUTHORIZED REPRESENTATIVE SHALL BE OF GOOD MORAL CHARACTER.

(4) THE DEPARTMENT SHALL NOT ISSUE A LICENSE TO OR RENEW THE LICENSE OF AN OWNER, OPERATOR, OR MEMBER OF THE GOVERNING BODY, WHO HAS REGULAR DIRECT ACCESS TO RESIDENTS OR WHO HAS ON-SITE FACILITY OPERATIONAL RESPONSIBILITIES, OR AN APPLICANT, IF AN INDIVIDUAL OR THE AUTHORIZED REPRESENTATIVE, IF ANY OF THOSE INDIVIDUALS HAVE

BEEN CONVICTED OF 1 OR MORE OF THE FOLLOWING:

(A) A FELONY UNDER THIS ACT OR UNDER CHAPTER XXA OF THE MICHIGAN PENAL CODE, 1931 PA 328, MCL 750.145M TO 750.145R.

(B) A MISDEMEANOR UNDER THIS ACT OR UNDER CHAPTER XXA OF THE MICHIGAN PENAL CODE, 1931 PA 328, MCL 750.145M TO 750.145R, WITHIN THE 10 YEARS IMMEDIATELY PRECEDING THE APPLICATION.

(C) A MISDEMEANOR INVOLVING ABUSE, NEGLECT, ASSAULT, BATTERY, OR CRIMINAL SEXUAL CONDUCT OR INVOLVING FRAUD OR THEFT AGAINST A VULNERABLE ADULT AS THAT TERM IS DEFINED IN SECTION 145M OF THE MICHIGAN PENAL CODE, 1931 PA 328, MCL 750.145M, OR A STATE OR FEDERAL CRIME THAT IS SUBSTANTIALLY SIMILAR TO A MISDEMEANOR DESCRIBED IN THIS SUBDIVISION WITHIN THE 10 YEARS IMMEDIATELY PRECEDING THE APPLICATION.

(5) THE APPLICANT FOR A LICENSE FOR AN ASSISTED LIVING FACILITY, IF AN INDIVIDUAL, MUST GIVE WRITTEN CONSENT AT THE TIME OF LICENSE APPLICATION AND THE AUTHORIZED REPRESENTATIVE MUST GIVE WRITTEN CONSENT AT THE TIME OF APPOINTMENT, FOR THE DEPARTMENT OF STATE POLICE TO CONDUCT BOTH OF THE FOLLOWING:

(A) A CRIMINAL HISTORY CHECK.

(B) A CRIMINAL RECORDS CHECK THROUGH THE FEDERAL BUREAU OF INVESTIGATION.

(6) UNLESS ALREADY SUBMITTED UNDER SUBSECTION (5), AN OWNER, OPERATOR, OR MEMBER OF THE GOVERNING BODY WHO HAS REGULAR DIRECT ACCESS TO RESIDENTS OR WHO HAS ON-SITE FACILITY OPERATIONAL RESPONSIBILITIES FOR AN ASSISTED LIVING FACILITY MUST GIVE WRITTEN CONSENT AT THE TIME OF LICENSE APPLICATION FOR THE DEPARTMENT OF STATE POLICE TO CONDUCT BOTH OF THE FOLLOWING:

(A) A CRIMINAL HISTORY CHECK.

(B) A CRIMINAL RECORDS CHECK THROUGH THE FEDERAL BUREAU OF INVESTIGATION.

(7) THE DEPARTMENT SHALL REQUIRE THE APPLICANT, AUTHORIZED REPRESENTATIVE, OWNER, OPERATOR, OR MEMBER OF THE GOVERNING BODY WHO HAS REGULAR DIRECT ACCESS TO RESIDENTS OR WHO HAS ON-SITE FACILITY OPERATIONAL RESPONSIBILITIES TO SUBMIT HIS OR HER FINGERPRINTS TO THE DEPARTMENT OF STATE POLICE FOR THE CRIMINAL HISTORY CHECK AND CRIMINAL RECORDS CHECK DESCRIBED IN SUBSECTIONS (5) AND (6).

(8) NOT LATER THAN 1 YEAR AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SECTION, ALL OWNERS, OPERATORS, AND MEMBERS OF THE GOVERNING BODY OF ASSISTED LIVING FACILITIES WHO HAVE REGULAR DIRECT ACCESS TO RESIDENTS OR WHO HAVE ON-SITE FACILITY OPERATIONAL RESPONSIBILITIES AND ALL AUTHORIZED REPRESENTATIVES MUST COMPLY WITH THE REQUIREMENTS OF THIS SECTION.

(9) THE DEPARTMENT SHALL REQUEST A CRIMINAL HISTORY CHECK AND CRIMINAL RECORDS CHECK IN THE MANNER PRESCRIBED BY THE DEPARTMENT OF STATE POLICE. THE DEPARTMENT OF STATE POLICE SHALL CONDUCT THE CRIMINAL HISTORY CHECK AND PROVIDE A REPORT OF THE RESULTS TO THE DEPARTMENT. THE REPORT SHALL CONTAIN ANY CRIMINAL HISTORY INFORMATION ON THE PERSON MAINTAINED BY THE DEPARTMENT OF STATE POLICE AND THE RESULTS OF THE CRIMINAL RECORDS CHECK FROM THE FEDERAL BUREAU OF INVESTIGATION. THE DEPARTMENT OF STATE POLICE MAY CHARGE THE PERSON ON WHOM THE CRIMINAL HISTORY CHECK AND CRIMINAL RECORDS CHECK ARE PERFORMED UNDER THIS SECTION A FEE FOR THE CHECKS REQUIRED UNDER THIS SECTION THAT DOES NOT EXCEED THE ACTUAL COST

AND REASONABLE COST OF CONDUCTING THE CHECKS.

(10) BEGINNING THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SECTION, IF AN APPLICANT, AUTHORIZED REPRESENTATIVE, OWNER, OPERATOR, OR MEMBER OF THE GOVERNING BODY WHO HAS REGULAR DIRECT ACCESS TO RESIDENTS OR WHO HAS ON-SITE FACILITY OPERATIONAL RESPONSIBILITIES APPLIES FOR A LICENSE OR TO RENEW A LICENSE TO OPERATE AN ASSISTED LIVING FACILITY AND PREVIOUSLY UNDERWENT A CRIMINAL HISTORY CHECK AND CRIMINAL RECORDS CHECK REQUIRED UNDER SUBSECTION (5) OR (6) OR UNDER SECTION 134A OF THE MENTAL HEALTH CODE, 1974 PA 258, MCL 330.1134A, AND HAS REMAINED CONTINUOUSLY LICENSED OR CONTINUOUSLY EMPLOYED UNDER SECTION 20173A OR UNDER SECTION 34B OF THE ADULT FOSTER CARE FACILITY LICENSING ACT, 1979 PA 218, MCL 400.734B, AFTER THE CRIMINAL HISTORY CHECK AND CRIMINAL RECORDS CHECK HAVE BEEN PERFORMED, THE APPLICANT, AUTHORIZED REPRESENTATIVE, OWNER, OPERATOR, OR MEMBER OF THE GOVERNING BODY WHO HAS REGULAR DIRECT ACCESS TO RESIDENTS OR WHO HAS ON-SITE FACILITY OPERATIONAL RESPONSIBILITIES IS NOT REQUIRED TO SUBMIT TO ANOTHER CRIMINAL HISTORY CHECK OR CRIMINAL RECORDS CHECK UPON RENEWAL OF THE LICENSE OBTAINED UNDER THIS SECTION.

(11) THE DEPARTMENT OF STATE POLICE SHALL STORE AND MAINTAIN ALL FINGERPRINTS SUBMITTED UNDER THIS ACT IN AN AUTOMATED FINGERPRINT IDENTIFICATION SYSTEM DATABASE THAT PROVIDES FOR AN AUTOMATIC NOTIFICATION AT THE TIME A SUBSEQUENT CRIMINAL ARREST FINGERPRINT CARD SUBMITTED INTO THE SYSTEM MATCHES A SET OF FINGERPRINTS PREVIOUSLY SUBMITTED IN ACCORDANCE WITH THIS ACT. AT THE TIME OF THAT NOTIFICATION, THE DEPARTMENT OF STATE POLICE SHALL IMMEDIATELY NOTIFY THE DEPARTMENT. THE DEPARTMENT SHALL TAKE THE

APPROPRIATE ACTION UPON NOTIFICATION BY THE DEPARTMENT OF STATE POLICE UNDER THIS SUBSECTION.

(12) AN APPLICANT, OWNER, OPERATOR, MEMBER OF A GOVERNING BODY, OR AUTHORIZED REPRESENTATIVE OF AN ASSISTED LIVING FACILITY SHALL NOT BE PRESENT IN AN ASSISTED LIVING FACILITY IF HE OR SHE HAS BEEN CONVICTED OF EITHER OF THE FOLLOWING:

(A) VULNERABLE ADULT ABUSE, NEGLECT, OR FINANCIAL EXPLOITATION.

(B) A LISTED OFFENSE AS DEFINED IN SECTION 2 OF THE SEX OFFENDERS REGISTRATION ACT, 1994 PA 295, MCL 28.722.

Enacting section 1. This amendatory act takes effect 90 days after the date it is enacted into law.