HOUSE BILL NO. 6438

October 11, 2022, Introduced by Reps. Pohutsky, Haadsma, Aiyash, Puri, Young, Hood, Weiss, Morse, Hope, Tyrone Carter, Sabo, LaGrand and Rogers and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 17101, 20104, 20106, and 20161 (MCL 333.17101, 333.20104, 333.20106, and 333.20161), section 17101 as added by 2016 PA 417, sections 20104 and 20161 as amended by 2022 PA 187, and section 20106 as amended by 2017 PA 167, and by adding part 207 and section 22224c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 17101. (1) As used in this part:

(a) "Appropriate health professional", for the purposes of referral, consultation, or collaboration with a midwife under this part, means any of the following:

(*i*) A physician.

(*ii*) A certified nurse midwife.

(*iii*) As identified in rules promulgated under section 17117, another appropriate health professional licensed, registered, or otherwise authorized to engage in a health profession under this article.

(b) "Certified nurse midwife" means a registered professional nurse under part 172 who has been granted a specialty certification in the profession specialty field of nurse midwifery by the board of nursing under section 17210.

(c) "Health care provider" means an individual who is licensed or registered under this article.

(d) "Midwife" means an individual licensed under this part to engage in the practice of midwifery.

(e) "Physician" means an individual licensed to engage in the practice of medicine under part 170 or the practice of osteopathic medicine and surgery under part 175.

(f) "Practice of midwifery", subject to subsection (2), means providing maternity care that is consistent with a midwife's training, education, and experience, to ~~women~~ **individuals** and neonates during the antepartum, intrapartum, and postpartum periods.

(2) For purposes of this part, practice of midwifery does not include either of the following:

(a) The practice of medicine or osteopathic medicine and surgery.

(b) The practice of nursing, including the practice of nursing with a specialty certification in the profession specialty field of nurse midwifery under part 172.

(3) In addition to the definitions of this part, article 1 contains general definitions and principles of construction applicable to all articles in this code and part 161 contains definitions applicable to this part.

Sec. 20104. (1) Except as otherwise provided in part 221, "certification" means the issuance of a document by the department to a health facility or agency attesting to the fact that the health facility or agency meets both of the following:

(a) It complies with applicable statutory and regulatory requirements and standards.

(b) It is eligible to participate as a provider of care and services in a specific federal or state health program.

(2) "Consumer" means a person who is not a health care provider as that term is defined in 42 USC 300jj.

(3) "County medical care facility" means a nursing care facility, other than a hospital long-term care unit, that provides organized nursing care and medical treatment to 7 or more unrelated individuals who are suffering or recovering from illness, injury, or infirmity and that is owned by a county or counties.

(4) "Department" means the department of licensing and regulatory affairs.

(5) "Direct access" means access to a patient or resident or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.

(6) "Director" means the director of the department.

(7) "Freestanding birth center" means that term as defined in section 20701.

(8) ~~(7)~~ "Freestanding surgical outpatient facility" means a facility, other than the office of a physician, dentist, podiatrist, or other private practice office, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care. Freestanding surgical outpatient facility does not include a surgical outpatient facility owned by and operated as part of a hospital.

(9) ~~(8)~~ "Good moral character" means that term as defined in, and determined under, 1974 PA 381, MCL 338.41 to 338.47.

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 freestanding birth center.

(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. 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) Freestanding birth center.....	**$500.00 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, the hospital shall pay a license fee surcharge of $23.00 per bed. As used in this subsection:

(a) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-6.

(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)~~ **(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 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 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)** 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).~~ **(1)(h).**

(k) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(h)** 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)~~ **(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 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).~~ **(1)(i).** 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),~~ **(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 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),~~ **(1)(i),** except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** 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)~~ **(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 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 207. FREESTANDING BIRTH CENTERS

Sec. 20701. (1) As used in this part:

(a) "Freestanding birth center" means an agency, other than a hospital or freestanding surgical outpatient facility, providing midwifery care, low-risk deliveries, and newborn care immediately after delivery.

(b) "Health care provider" means any of the following:

(*i*) A physician.

(*ii*) A physician's assistant licensed under part 170 or 175.

(*iii*) An advanced practice registered nurse as that term is defined in section 17201.

(*iv*) A midwife.

(c) "Low-risk delivery" means a prenatal course of labor and birth, as defined by the Michigan board of licensed midwifery by rule.

(d) "Midwife" means that term as defined in section 17101.

(e) "Midwifery care" means the practice of midwifery as that term is defined in section 17101 through a midwife.

(f) "Physician" means that term as defined in section 17001 or 17501.

(g) "Social determinants of health" means the social and economic conditions that influence individual and group differences in health status.

(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. 20711. (1) A freestanding birth center must be licensed under this article.

(2) "Freestanding birth center", "birth center", or a similar

term or abbreviation must not be used to describe or refer to a health facility or agency unless it is licensed by the department under this article.

Sec. 20713. The owner, operator, and governing body of a freestanding birth center licensed under this article:

(a) Are responsible for all phases of the operation of the freestanding birth center, selection of health care providers, and quality of care rendered in the freestanding birth center.

(b) Shall cooperate with the department in the enforcement of this article and require that the health care providers and other personnel working in the facility and for whom a state license or registration is required be currently licensed or registered.

(c) Shall ensure that health care providers are of a sufficient number and have the qualifications, training, and skills necessary to meet operational and patient needs, considering the caseload and size of the freestanding birth center.

Sec. 20715. Subject to this part, part 171, and any rules promulgated for purposes of this part and part 171, a freestanding birth center shall comply with all of the following:

(a) Have a plan to identify social determinants of health and, if the freestanding birth center considers it necessary, refer a patient to a support service to address a patient's social determinants of health. For purposes of this subdivision, "support service" includes, but is not limited to, a food assistance program, a counseling service, an early childhood development resource, or an intimate partner violence support group.

(b) Develop, implement, and enforce written policies and procedures for the freestanding birth center's operations. The policies and procedures must be made available to health care

providers and other personnel who are employed by or under contract with the freestanding birth center and must comply with all of the following:

(*i*) Be consistent with professional recognized standards of practice.

(*ii*) Be administered in a manner that provides quality health care services in a safe environment.

(*iii*) Include a plan for consulting with other persons for services that are not directly provided by the freestanding birth center, including, but not limited to, outside laboratory services, lactation support services, childbirth education, transfers to hospitals, and consultation with physicians who specialize in pediatrics and obstetrics and gynecology.

(c) Provide services in a community setting with adequate space for furnishings, equipment, supplies, accommodations for patients and the families of patients.

Sec. 20717. (1) A freestanding birth center shall not do any of the following:

(a) Except as otherwise provided in this subdivision, use general or regional anesthesia, including an epidural. Local anesthesia, systemic analgesia, nitrous oxide, and other forms of pain relief may be administered at the freestanding birth center if all of the following are met:

(*i*) It is determined to be medically necessary by a health care provider.

(*ii*) It is administered by a health care provider who is acting within the scope of the health care provider's practice.

(*iii*) It is used according to the freestanding birth center's policies and procedures.

(b) Induce, stimulate, or augment labor with pharmacologic agents during the first or second stages of labor or before labor.

(c) Perform surgical procedures other than episiotomies or repairs of perineal lacerations.

(d) Use vacuum extractors, vaginal forceps, or continuous electronic fetal monitoring.

(e) Except as otherwise provided in subsection (4), allow a patient to deliver at the freestanding birth center if the patient is not considered to be a patient with a low-risk delivery. A patient is not considered to be a patient with a low-risk delivery if any of the following risk factors apply:

(*i*) There is known breech or nonvertex presentation at the time of the patient's admission.

(*ii*) Multiple gestation.

(*iii*) Gestation less than 36 weeks and 0 days or gestation greater than 42 weeks and 0 days.

(*iv*) Any other risk factor established by the freestanding birth center under subsection (2).

(2) A freestanding birth center shall develop written risk factors that, when present, would preclude a patient being considered a patient with a low-risk delivery and from delivering at the freestanding birth center.

(3) A freestanding birth center shall develop policies and procedures for assessing a patient seeking perinatal care to determine whether the patient is considered a patient with a low-risk delivery and to determine whether a full-term, spontaneous vaginal birth is anticipated.

(4) A freestanding birth center may allow a patient to deliver at the freestanding birth center if there is insufficient time to

initiate the transfer of the patient to a hospital before the expected birth of the patient's child.

Sec. 20719. (1) A freestanding birth center shall provide quality intrapartum care that promotes physiologic birth, including, but not limited to, all of the following:

(a) Respectful, supportive care during labor.

(b) Minimization of stress-inducing stimuli.

(c) Freedom of movement.

(d) Oral intake, as appropriate.

(e) Availability of nonpharmacologic pain relief methods.

(f) Regular and appropriate assessment of the patient and fetus throughout labor.

(2) The freestanding birth center shall ensure that a health care provider is present or available to the patient at all times when a patient is admitted to the freestanding birth center and until the patient and the newborn are determined to be clinically stable, based on criteria established by the freestanding birth center.

(3) The freestanding birth center shall ensure that a health care provider monitors the progress of a patient's labor and the condition of the patient at intervals established in the freestanding birth center's policies and procedures. The freestanding birth center shall also comply with all of the following:

(a) Subject to section 20717 and 17107 and any rules promulgated under part 171, initiate the transfer of the patient to a hospital if complications occur that render the patient ineligible for care at the freestanding birth center.

(b) Subject to this subdivision, have the personnel and

equipment necessary to respond to medical emergencies that may arise while providing services to a patient in the freestanding birth center, including, but not limited to, basic life support, neonatal resuscitation, and the initial management of postpartum complications. The freestanding birth center shall ensure that at least 2 individuals who are certified in basic life support and neonatal resuscitation are on the premises and immediately available during a delivery.

Sec. 20721. (1) A freestanding birth center shall not discharge a patient from the birth center until the patient is clinically stable and has met discharge criteria established by the freestanding birth center.

(2) A freestanding birth center shall ensure that a program for follow-up care and postpartum evaluation is planned for each patient.

Sec. 20723. (1) A freestanding birth center shall recommend that personnel receive an annual vaccination against influenza.

(2) A freestanding birth center shall provide evidence to the department, on request, of immunization, positive titer result, or documentation of refusal for personnel of the freestanding birth center for each of the following:

(a) Rubella.

(b) Tdap.

(c) Hepatitis B.

(d) Varicella.

(3) A freestanding birth center shall conduct tuberculosis testing before employing or entering into a contract with an individual who will work in the freestanding birth center.

Sec. 21537. A hospital that admits a patient for care during

labor and delivery of the patient's child shall ensure that the hospital has a program for follow-up care and for the postpartum evaluation for the patient.

Sec. 22224c. A freestanding birth center as that term is defined in section 20701 is not required to obtain a certificate of need.