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STATE OF MICHIGAN
102ND LEGISLATURE
REGULAR SESSION OF 2024

Introduced by Rep. Pohutsky

ENROLLED HOUSE BILL No. 5636

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," by amending sections 2811, 2823, 17101, 20104, 20106, and 20161 (MCL 333.2811, 333.2823, 333.17101, 333.20104, 333.20106, and 333.20161), section 2811 as amended by 1998 PA 332, section 17101 as added by 2016 PA 417, section 20104 as amended by 2022 PA 187, section 20106 as amended by 2017 PA 167, and section 20161 as amended by 2023 PA 138, and by adding sections 2823a and 22224c and part 207.

The People of the State of Michigan enact:

Sec. 2811. The department shall prescribe the form and content of vital records and certificates, which, except as otherwise provided in this part, must conform as nearly as possible to recognized national standardized forms including, as required to comply with federal law, requirements for the entry of Social Security numbers.

Sec. 2823. (1) When a live birth occurs in a moving conveyance in the United States and the child is first removed from the conveyance in this state, the birth must be registered in this state. Except as otherwise provided in section 2823a, the place where the child is first removed from the conveyance must be shown as the place of birth.

(2) When a live birth occurs in a moving conveyance while in international waters or air space or a foreign country and the child is first removed from the conveyance in this state, the birth must be registered in this state but the certificate must show the actual place of birth if the place can be determined.

Sec. 2823a. (1) Except as otherwise provided in subsection (2), when a live birth occurs in this state, the place of birth must be listed on the certificate as follows:

(a) If the live birth occurs in an institution or en route to an institution, the place of birth must be listed as the institution.

(b) If the live birth occurs in or en route to a freestanding birth center licensed under article 17, the place of birth must be listed as the freestanding birth center.

(c) If the live birth occurs in a home, the place of birth must be listed as "home".

(2) The place of birth of a child of unknown parentage who is found is as provided in section 2825.

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 licensed under part 172 who has been granted a specialty certification in the health profession specialty field of nurse midwifery by the Michigan 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 perinatal care that is consistent with a midwife's training, education, and experience, to 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 health 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) "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) "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, 2027, 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..... $500.00 per facility license and $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) 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) 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) Initial licensure application fee for subdivisions (a), (b), (c), (d), (e), (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-8.

(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)(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)(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)(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)(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)(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)(h).

(k) The state retention amount of the quality assurance assessment collected under subsection (1)(h) must be equal to 13.2% of the federal funds generated by the 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, 2027, 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)(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)(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)(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 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)(i), except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection (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)(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. Beginning in the fiscal year ending September 30, 2018, and for each fiscal year thereafter, there is a retention amount of at least $118,420,600.00 for each fiscal year for the Healthy Michigan plan. By May 31 of each year, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount 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.

(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, 2027. 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) By November 1 of each year, 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) 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) "Certified nurse midwife" means an individual who is licensed as a registered professional nurse under part 172 who has been granted a specialty certification in the health profession specialty field of nurse midwifery by the Michigan board of nursing under section 17210.

(b) "Freestanding birth center" means a facility that provides midwifery care for normal deliveries, well-person reproductive and sexual health care, extended postpartum care, and newborn care, that is within the scope of practice of the health care provider. Freestanding birth center does not include a hospital or freestanding surgical outpatient facility.

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

(*i*) A physician.

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

(*iii*) A certified nurse midwife.

(*iv*) A midwife.

(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 by a midwife and the practice of nursing by a certified nurse 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" 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 freestanding birth center and for whom a state license or registration is required be currently licensed or registered.

(c) Subject to sections 20719 and 20721, shall ensure that health care providers are of a sufficient number to maintain safety and quality of care and have the qualifications, training, and skills necessary to meet operational needs and the needs of a patient, 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 needs caused by social determinants of health and, with the consent of a patient, refer the patient to a support service to address the patient's needs. 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, a housing assistance program, 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 administered in a manner that provides quality health care services in a safe environment.

(*ii*) Identify a process for hiring, credentialing, and training staff.

(*iii*) Ensure that the right of a patient to informed consent and to refuse treatment is upheld at every stage of care.

(*iv*) Include a process by which health care providers who are employed by or under contract with the freestanding birth center comply with all of the following:

(A) Refer a patient to services that are not directly provided by the freestanding birth center, including, but not limited to, outside laboratory testing services, lactation support services, and childbirth education.

(B) Consult with another health care provider.

(C) Refer a patient to another health care provider.

(D) Transfer the care of a patient to another health care provider with the informed consent of the patient.

(E) Initiate patient transport to a hospital described under subdivision (e) when needed by calling 9-1-1 or an ambulance operation or by arranging other means for patient transport.

(F) Notify a hospital described under subdivision (e) of the freestanding birth center's license.

(*v*) Include a process by which a patient's medical record is provided to another health care provider upon the patient's request or if the patient is transferred as described in subparagraph (*iv*)(D) or (E).

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

(d) Ensure that a patient is notified of each health care provider within the freestanding birth center who maintains a malpractice liability insurance policy and each health care provider who does not.

(e) Identify a hospital to which a patient may be transferred from the freestanding birth center and that is in close proximity to the freestanding birth center.

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 epidural anesthesia. Local anesthesia, 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 clinically 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 and according to the professionally recognized standards of practice described in section 20727.

(b) Use pharmacologic agents to induce, stimulate, or augment labor, or bring about cervical ripening, during the first or second stages of labor or before labor. A freestanding birth center may use pharmacologic agents during the delivery of a placenta and in the postpartum period.

(c) Perform surgical procedures other than the following:

(*i*) Episiotomies.

(*ii*) Repairs of perineal lacerations.

(*iii*) Circumcisions.

(*iv*) Newborn frenulum revisions.

(*v*) Any other surgical procedure that is authorized by the department by rule.

(d) Use vacuum extractors or vaginal forceps.

(e) Except as otherwise provided in subsection (3), permit a patient to deliver at the freestanding birth center if any of the following limiting factors apply:

(*i*) Fetal gestation is less than 36 weeks and 0 days.

(*ii*) Labor has not started before fetal gestation of 42 weeks and 1 day.

(*iii*) Any other limiting factor established by rule under section 20727 is present in the patient or the clinical needs of the patient fall outside the scope of practice of a health care provider at the freestanding birth center.

(2) A freestanding birth center shall develop policies and procedures for assessing a patient seeking perinatal care to determine whether it is appropriate for the patient to deliver at the freestanding birth center.

(3) A freestanding birth center may permit a patient who meets a limiting factor described in subsection (1) or in rules promulgated under section 20727 to deliver at the freestanding birth center if there is insufficient time to convey the responsibility for the care of the patient to a hospital before the fetus is born.

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

(a) Respectful, supportive care during labor, for which the patient has provided consent.

(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 provide a patient, at the inception of care, with all of the following information:

(a) A written description of the training, philosophy of practice, qualifications, and license or specialty certification of a health care provider who is employed by or under contract with the freestanding birth center.

(b) A written description of the freestanding birth center's patient practice policies.

(c) The complaint process for state and national credentialing organizations for a health care provider who is employed by or under contract with the freestanding birth center.

(3) 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.

(4) 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 and fetus or newborn at intervals established in the freestanding birth center's policies and procedures.

(5) Subject to this subsection, the freestanding birth center shall have the personnel and equipment necessary to ensure patient safety, meet the demands for services that are routinely provided in the freestanding birth center, provide coverage during periods of high demand or in the case of an emergency, and respond to patient health emergencies that may arise while a patient is receiving services 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 are on the premises and immediately available during a delivery who are certified in basic life support from the American Heart Association or an equivalent organization as determined by the department and are certified in neonatal resuscitation from the American Academy of Pediatrics, the American Heart Association, or an equivalent organization, as determined by the department.

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.

(3) A freestanding birth center shall ensure that both of the following are available to a patient of the freestanding birth center 24 hours a day and 7 days a week:

(a) Consultation with a health care provider by telephone.

(b) A health care provider or other personnel who are available on call to provide intrapartum care to the patient.

Sec. 20722. (1) The department shall not require a freestanding birth center to do any of the following:

(a) Maintain a collaborative agreement with another health facility or agency or with a health care provider who is not employed by or under contract with a freestanding birth center.

(b) Provide care other than midwifery care.

(2) Subsection (1) does not limit a freestanding birth center from maintaining a collaborative agreement or providing care other than midwifery care as described under subsection (1).

Sec. 20723. (1) A freestanding birth center shall recommend that health care providers and other personnel who are employed by or under contract with the freestanding birth center receive an annual vaccination against influenza and recommend that health care providers and other personnel who are employed by or under contract with the freestanding birth center are fully vaccinated against COVID-19.

(2) A freestanding birth center shall provide evidence to the department, on request, of immunization, positive titer result, or documentation of refusal for health care providers and other personnel who are employed by or under contract with the freestanding birth center, for each of the following:

(a) Rubella.

(b) Tdap.

(c) Hepatitis B.

(d) Varicella.

(e) Against any other disease required by the department by rule.

(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. 20727. The department, in consultation with representatives of freestanding birth centers, the Michigan Affiliate of the American College of Nurse-Midwives, the Michigan Midwives Association, the Michigan board of nursing, the Michigan board of licensed midwifery, and the State of Birth Justice, shall promulgate rules to implement this part. The rules must include at least all of the following:

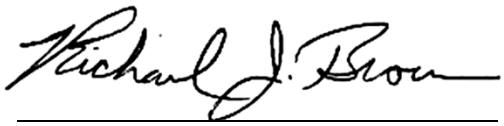
(a) Professionally recognized standards of practice based on standards issued by the American Association of Birth Centers, the American College of Nurse-Midwives, and the National Association of Certified Professional Midwives. If any of the standards described in this subdivision are revised after the effective date of the amendatory act that added this section, the department shall take notice of the revision. The department, in consultation with the persons described in this section, may promulgate rules to incorporate any revision by reference.

(b) Limiting factors that, when present, would preclude a patient from delivering at the freestanding birth center because the patient is not considered to be a patient with a normal delivery. The rules must allow a freestanding birth center to develop policies that would include additional limiting factors to preclude delivery at the freestanding birth center.

Sec. 20729. Notwithstanding part 201, the department shall not enforce this part or any rules promulgated for purposes of this part, including, but not limited to, the requirement that a freestanding birth center be licensed under this article, until 2 years after the effective date of the amendatory act that added this part.

Sec. 20735. This part does not require new or additional third-party reimbursement or mandated worker's compensation benefits for services rendered at a freestanding birth center.

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



Clerk of the House of Representatives

Secretary of the Senate

Approved_____

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Governor