

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

ARTICLE 17
FACILITIES AND AGENCIES

PART 201
GENERAL PROVISIONS

333.20101 Meanings of words and phrases; principles of construction.

Sec. 20101. (1) The words and phrases defined in sections 20102 to 20109 apply to all parts in this article except part 222 and have the meanings ascribed to them in those sections.

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

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

For transfer of powers and duties of the bureau of family services from the department of consumer and industry services to the family independence agency by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.20102 Definitions; A.

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.

(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.

(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.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1981, Act 79, Imd. Eff. June 30, 1981;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2010, Act 381, Imd. Eff. Dec. 22, 2010.

Popular name: Act 368

333.20104 Definitions; C to G.

Sec. 20104. (1) "Certification" means the issuance of a document by the department to a health facility or agency attesting to the fact that the 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) "Clinical laboratory" means a facility patronized by, or at the direction of, a physician, health officer, or other person authorized by law to obtain information for the diagnosis, prevention, or treatment of disease or the assessment of a medical condition by the microbiological, serological, histological, hematological, immunohematological, biophysical, cytological, pathological, or biochemical examination of materials derived from the human body, except as provided in section 20507.

(3) "Consumer" means a person who is not a provider of health care as defined in section 1531(3) of title 15 of the public health service act, 42 USC 300n.

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

(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) "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. It does not include a surgical outpatient facility owned by and operated as part of a hospital.

(7) "Good moral character" means that term as defined in section 1 of 1974 PA 381, MCL 338.41.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2010, Act 381, Imd. Eff. Dec. 22, 2010.

Popular name: Act 368

333.20106 Definitions; H.

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 clinical laboratory.

(c) A county medical care facility.

(d) A freestanding surgical outpatient facility.

(e) A health maintenance organization.

(f) A home for the aged.

(g) A hospital.

(h) A nursing home.

(i) A hospice.

(j) A hospice residence.

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

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

(3) "Home for the aged" means a supervised personal care facility, 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.

(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 community health 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.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1981, Act 79, Imd. Eff. June 30, 1981;—Am. 1982, Act 354, Imd. Eff. Dec. 21, 1982;—Am. 1984, Act 311, Eff. Mar. 29, 1985;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1996, Act 267, Imd. Eff. June 12, 1996;—Am. 2000, Act 253, Imd. Eff. June 29, 2000.

Popular name: Act 368

333.20108 Definitions; I to N.

Sec. 20108. (1) "Intermediate care facility" means a hospital long-term care unit, nursing home, county medical care facility, or other nursing care facility, or distinct part thereof, certified by the department to provide intermediate care or basic care that is less than skilled nursing care but more than room and board.

(2) "License" means an authorization, annual or as otherwise specified, granted by the department and evidenced by a certificate of licensure or permit granting permission to a person to establish or maintain and operate, or both, a health facility or agency. For purposes of part 209, "license" includes a license issued to an individual under that part.

(3) "Licensee" means the holder of a license or permit to establish or maintain and operate, or both, a health facility or agency. For purposes of part 209, "licensee" includes an individual licensed under that part.

(4) "Limited license" means a provisional license or temporary permit or a license otherwise limited as prescribed by the department.

(5) "Medically contraindicated" means, with reference to nursing homes only, having a substantial adverse effect on the patient's physical health, as determined by the attending physician, which effect is explicitly

stated in writing with the reasons therefor in the patient's medical record.

(6) "Medical first response service" means that term as defined in section 20906.

(7) "Nontransport prehospital life support operation" means that term as defined in section 20908.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1986, Act 78, Imd. Eff. Apr. 7, 1986;—Am. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20109 Definitions; N to S.

Sec. 20109. (1) "Nursing home" means a nursing care facility, including a county medical care facility, that provides organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity. Nursing home does not include a unit in a state correctional facility. Nursing home does not include 1 or more of the following:

(a) A hospital.

(b) A veterans facility created under Act No. 152 of the Public Acts of 1885, being sections 36.1 to 36.12 of the Michigan Compiled Laws.

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

(d) A hospice that is certified under 42 C.F.R. 418.100.

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

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

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

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1991, Act 39, Imd. Eff. June 11, 1991;—Am. 1996, Act 224, Eff. June 12, 1996.

Popular name: Act 368

333.20115 Rules defining or differentiating health facility or agency; republication of certain rules; waiver or modification; "abortion" defined.

Sec. 20115. (1) The department may promulgate rules to further define the term "health facility or agency" and the definition of a health facility or agency listed in section 20106 as required to implement this article. The department may define a specific organization as a health facility or agency for the sole purpose of certification authorized under this article. For purpose of certification only, an organization defined in section 20106(5), 20108(1), or 20109(4) is considered a health facility or agency. The term "health facility or agency" does not mean a visiting nurse service or home aide service conducted by and for the adherents of a church or religious denomination for the purpose of providing service for those who depend upon spiritual means through prayer alone for healing.

(2) The department shall promulgate rules to differentiate a freestanding surgical outpatient facility from a private office of a physician, dentist, podiatrist, or other health professional. The department shall specify in the rules that a facility including, but not limited to, a private practice office described in this subsection in which 50% or more of the patients annually served at the facility undergo an abortion must be licensed under this article as a freestanding surgical outpatient facility.

(3) The department shall promulgate rules that in effect republish R 325.3826, R 325.3832, R 325.3835, R 325.3857, R 325.3866, R 325.3867, and R 325.3868 of the Michigan administrative code, but shall include in the rules standards for a freestanding surgical outpatient facility in which 50% or more of the patients annually served in the freestanding surgical outpatient facility undergo an abortion. The department shall assure that the standards are consistent with the most recent United States supreme court decisions regarding state regulation of abortions.

(4) Subject to section 20145 and part 222, the department may modify or waive 1 or more of the rules contained in R 325.3801 to R 325.3877 of the Michigan administrative code regarding construction or equipment standards, or both, for a freestanding surgical outpatient facility in which 50% or more of the patients annually served in the freestanding surgical outpatient facility undergo an abortion, if both of the following conditions are met:

(a) The freestanding surgical outpatient facility was in existence and operating on the effective date of the amendatory act that added this subsection.

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

(5) As used in this subsection, “abortion” means that term as defined in section 17015.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1999, Act 206, Eff. Mar. 10, 2000.

Popular name: Act 368

Administrative rules: R 325.3801 et seq. and R 325.23101 et seq. of the Michigan Administrative Code.

333.20121 Health facilities and agencies advisory commission; creation; appointment and qualification of members; director as ex officio member without vote.

Sec. 20121. The health facilities and agencies advisory commission is created in the department. The governor shall appoint the members with the advice and consent of the senate. Half the members shall be consumers and half the members shall be representative of different types of licensees, with at least 1 representative of each type. Membership shall include at least 1 practicing physician, 1 registered nurse, and 1 enrollee of a health maintenance organization who is a consumer of health care. The director shall serve as an ex officio member of the advisory commission without vote.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the health facilities and agencies advisory commission to the director of the Michigan state department of public health, see E.R.O. No. 1994-1, compiled at MCL 333.26322 of the Michigan Compiled Laws.

Popular name: Act 368

333.20122 Advisory commission; terms of members; vacancy; removal.

Sec. 20122. (1) A member of the advisory commission shall serve for a term of 4 years or until a successor is appointed, except that the terms of members first appointed shall be as provided by section 1214. A member shall not serve more than 2 full terms and 1 partial term, consecutive or otherwise.

(2) A vacancy shall be filled in the same manner as an original appointment for the balance of the unexpired term.

(3) The director may recommend to the governor the removal of a member from the advisory commission at any time for poor attendance at meetings or other good cause.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20123 Advisory commission; meetings; chairperson and vice-chairperson; vacancy; quorum; expenses.

Sec. 20123. (1) The advisory commission shall meet at the call of its chairperson or the director at least twice each year.

(2) The advisory commission shall elect a chairperson and vice-chairperson for terms of 2 years. The chairperson shall be a consumer and the vice-chairperson a licensee representative. A vacancy in either office shall be filled by election for the balance of the unexpired term.

(3) The advisory commission shall determine the number of voting members that constitute a quorum for the transaction of business.

(4) Advisory commission members and task force members shall be reimbursed for expenses incurred in the performance of official duties as provided in section 1216.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20124 Advisory commission; duties generally.

Sec. 20124. The advisory commission shall:

(a) Approve rules relating to the licensure and certification of health facilities and agencies other than health maintenance organizations and the administration of this article before their promulgation.

(b) Receive reports of licenses denied, limited, suspended, or revoked pursuant to this article.

(c) Advise the department as to administration of health facility and agency licensure and certification functions, including recommendations with respect to licensing actions.

(d) Biennially conduct a review and prepare a written evaluation of health facility and agency licensure and

certification functions performed by the department, including appropriate recommendations. The recommendations shall give particular attention to policies as to public disclosure and nondiscrimination and the standardization and integration of rules common to more than 1 category of health facility or agency.

(e) Review complaints made under section 20176.

(f) Provide other assistance the department reasonably requests.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 2000, Act 253, Imd. Eff. June 29, 2000.

Popular name: Act 368

333.20126 Task forces; appointment; purpose; duties; membership; staff support.

Sec. 20126. (1) The advisory commission chairperson shall appoint 4 task forces to advise the commission in carrying out its duties as follows:

(a) Task force 1 shall assist in matters pertaining to the licensure and certification of health facilities and agencies under this part, except ambulance operations, aircraft transport operations, nontransport prehospital life support operations, medical first response services, health maintenance organizations, and nursing homes.

(b) Task force 2 shall assist in matters pertaining to the licensure of ambulance operations, aircraft transport operations, nontransport prehospital life support operations, and medical first response services under part 209.

(c) Task force 3 shall assist in matters pertaining to the licensure and certification of health maintenance organizations.

(d) Task force 4 shall assist in matters pertaining to the licensure of nursing homes as provided in section 20127.

(2) Except as provided by subsections (4), (5), and (6), each task force shall be composed of a number of advisory commission members to be determined by the chairperson. The chairperson with the approval of the director may appoint noncommission members to each task force as associate task force members if necessary to provide adequate expert professional and technical support.

(3) The department shall provide staff support to the advisory commission and its task forces.

(4) The state emergency medical services coordination committee created in section 20915 shall be appointed as task force 2 and shall perform the duties set forth in this section.

(5) Initial appointments to task force 3 shall include the members of the commission created by section 7 of former Act No. 264 of the Public Acts of 1974.

(6) Task force 4 shall be established as provided in section 20127.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1981, Act 79, Imd. Eff. June 30, 1981;—Am. 1990, Act 179, Imd. Eff. July 2, 1990.

Compiler's note: Act 264 of 1974, referred to in this section, was repealed by Act 368 of 1978 .

Popular name: Act 368

333.20127 Task force 4; purpose; appointment and qualifications of members; chairperson and vice-chairperson; quorum; procedures; duties.

Sec. 20127. (1) Task force 4 shall be composed of 15 state residents to review the operation of part 217 and rules promulgated under part 217, to hear and evaluate complaints in implementation of part 217, and to recommend to the legislature and the department changes in part 217 and the rules.

(2) The director shall appoint the task force members, 1 of whom shall be a nurse having a background in gerontology, 1 a social worker having a background in gerontology, 5 representatives of nursing homes, 3 representatives of public interest health consumer groups, and 5 public members, 3 of whom have or have had relatives in a nursing home. In addition, there shall be 2 ex officio members without vote, 1 representing the department of public health, and 1 representing the department of social services.

(3) A majority of the voting members of the task force shall be consumers.

(4) The task force annually shall elect a chairperson and a vice-chairperson.

(5) The task force shall determine what constitutes a quorum and may establish procedures for the conduct of its business.

(6) The task force shall be charged with the following tasks:

(a) Meeting at least 6 times a year, at the call of the chairperson, the director, or any 3 members of the committee.

(b) Receiving and commenting on drafts of proposed rules.

(c) Receiving and making recommendations regarding complaint investigation reports, decisions, and procedures.

(d) Making reports and recommendations on needed changes in statutes and rules.

- (e) Reviewing decisions as provided in section 21764.
- (f) Reviewing complaints received under section 21763.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20131 Comprehensive system of licensure and certification; establishment; purpose; certification of health facility or agency; coordination, cooperation, and agreements; public disclosure.

Sec. 20131. (1) The department shall establish a comprehensive system of licensure and certification for health facilities or agencies in accordance with this article to:

(a) Protect the health, safety, and welfare of individuals receiving care and services in or from a health facility or agency.

(b) Assure the medical accountability for reimbursed care provided by a certified health facility or agency participating in a federal or state health program.

(2) The department may certify a health facility or agency, or part thereof, defined in section 20106 or under section 20115 when certification is required by state or federal law, rule, or regulation.

(3) The department shall coordinate all functions in state government affecting health facilities and agencies licensed under this article and cooperate with other state agencies which establish standards or requirements for health facilities and agencies to assure necessary, equitable, and consistent state supervision of licensees without unnecessary duplication of survey, evaluation, and consultation services or complaint investigations. The department may enter into agreements with other state agencies necessary to accomplish this purpose.

(4) The department shall utilize public disclosure to improve the effectiveness of licensure.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20132 Regulation of medical or surgical treatment prohibited; control of communicable diseases; protection of individuals receiving care and services; standards for inpatient food service establishment; compliance.

Sec. 20132. (1) The department shall not regulate the medical or surgical treatment provided to an individual by his or her attending physician in a health facility or agency.

(2) This article does not affect the authority of the department to control communicable diseases or to take immediate action necessary to protect the public health, safety, and welfare of individuals receiving care and services in or from a health facility or agency.

(3) A license for a health facility or agency shall include the operation of an inpatient food service establishment within the facility or agency. Standards for an inpatient food service establishment shall be the same as those established under part 129. A health facility or agency issued a license under this article is considered in compliance with that part.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20141 Health facility or agency; license required; eligibility to participate in federal or state health program; personnel; services; and equipment; evidence of compliance; providing data and statistics.

Sec. 20141. (1) A person shall not establish or maintain and operate a health facility or agency without holding a license from the department.

(2) A health facility or agency is not eligible to participate in a federal or state health program requiring certification without current certification from the department.

(3) A health facility or agency shall have the physician, professional nursing, health professional, technical and supportive personnel, and the technical, diagnostic, and treatment services and equipment necessary to assure the safe performance of the health care undertaken by or in the facility or agency.

(4) Licensure and certification of a health facility or agency shall be evidence of the fact that the facility or agency complies with applicable statutory and regulatory requirements and standards at the time of issuance.

(5) A health facility or agency shall provide the department with the data and statistics required to enable the department to carry out functions required by federal and state law, including rules and regulations.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20142 Application for licensure and certification; form; certifying accuracy of information; disclosures, reports; and notices; violation; penalty; false statement as felony.

Sec. 20142. (1) A health facility or agency shall apply for licensure or certification on a form authorized and provided by the department. The application shall include attachments, additional data, and information required by the department.

(2) An applicant shall certify the accuracy of information supplied in the application and supplemental statements.

(3) An applicant or a licensee under part 213 or 217 shall disclose the names, addresses, principal occupations, and official positions of all persons who have an ownership interest in the health facility or agency. If the health facility or agency is located on or in leased real estate, the applicant or licensee shall disclose the name of the lessor and any direct or indirect interest the applicant or licensee has in the lease other than as lessee. A change in ownership shall be reported to the director not less than 15 days before the change occurs, except that a person purchasing stock of a company registered pursuant to the securities exchange act of 1934, 15 U.S.C. 78a to 78kk, is exempt from disclosing ownership in the facility. A person required to file a beneficial ownership report pursuant to section 16(a) of the securities exchange act of 1934, 15 U.S.C. 78p shall file with the department information relating to securities ownership required by the department rule or order. An applicant or licensee proposing a sale of a nursing home to another person shall provide the department with written, advance notice of the proposed sale. The applicant or licensee and the other parties to the sale shall arrange to meet with specified department representatives and shall obtain before the sale a determination of the items of noncompliance with applicable law and rules which shall be corrected. The department shall notify the respective parties of the items of noncompliance prior to the change of ownership and shall indicate that the items of noncompliance must be corrected as a condition of issuance of a license to the new owner. The department may accept reports filed with the securities and exchange commission relating to the filings. A person who violates this subsection is guilty of a misdemeanor, punishable by a fine of not more than \$1,000.00 for each violation.

(4) An applicant or licensee under part 217 shall disclose the names and business addresses of suppliers who furnish goods or services to an individual nursing home or a group of nursing homes under common ownership, the aggregate charges for which exceed \$5,000.00 in a 12-month period which includes a month in a nursing home's current fiscal year. An applicant or licensee shall disclose the names, addresses, principal occupations, and official positions of all persons who have an ownership interest in a business which furnishes goods or services to an individual nursing home or to a group of nursing homes under common ownership, if both of the following apply:

(a) The person, or the person's spouse, parent, sibling, or child has an ownership interest in the nursing home purchasing the goods or services.

(b) The aggregate charges for the goods or services purchased exceeds \$5,000.00 in a 12-month period which includes a month in the nursing home's current fiscal year.

(5) An applicant or licensee who makes a false statement in an application or statement required by the department pursuant to this article is guilty of a felony, punishable by imprisonment for not more than 4 years, or a fine of not more than \$30,000.00, or both.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20143 Compliance as condition to issuance of license, certificate, or certificate of need.

Sec. 20143. (1) A license or certificate under this part shall not be issued unless the applicant is in compliance with part 222.

(2) A licensee who is issued a certificate of need under part 222 shall comply with part 222 and all of the terms, conditions, and stipulations of the certificate of need.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.20144 Licensing on basis of approved building program.

Sec. 20144. A health facility or agency not meeting statutory and regulatory requirements for its physical plant and equipment may be licensed by the department on the basis of a building program approved by the department which:

(a) Sets forth a plan and timetable for correction of physical plant or equipment deficiencies and items of noncompliance.

(b) Includes documented evidence of the availability and commitment of money for carrying out the approved building program.

(c) Includes other documentation the department reasonably requires to assure compliance with the plan and timetable.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20145 Construction permit; certificate of need as condition of issuance; rules; information required for project not requiring certificate of need; review and approval of architectural plans and narrative; rules; waiver; fee; "capital expenditure" defined.

Sec. 20145. (1) Before contracting for and initiating a construction project involving new construction, additions, modernizations, or conversions of a health facility or agency with a capital expenditure of \$1,000,000.00 or more, a person shall obtain a construction permit from the department. The department shall not issue the permit under this subsection unless the applicant holds a valid certificate of need if a certificate of need is required for the project pursuant to part 222.

(2) To protect the public health, safety, and welfare, the department may promulgate rules to require construction permits for projects other than those described in subsection (1) and the submission of plans for other construction projects to expand or change service areas and services provided.

(3) If a construction project requires a construction permit under subsection (1) or (2), but does not require a certificate of need under part 222, the department shall require the applicant to submit information considered necessary by the department to assure that the capital expenditure for the project is not a covered capital expenditure as defined in section 22203(9).

(4) If a construction project requires a construction permit under subsection (1), but does not require a certificate of need under part 222, the department shall require the applicant to submit information on a 1-page sheet, along with the application for a construction permit, consisting of all of the following:

- (a) A short description of the reason for the project and the funding source.
- (b) A contact person for further information, including address and phone number.
- (c) The estimated resulting increase or decrease in annual operating costs.
- (d) The current governing board membership of the applicant.
- (e) The entity, if any, that owns the applicant.

(5) The information filed under subsection (4) shall be made publicly available by the department by the same methods used to make information about certificate of need applications publicly available.

(6) The review and approval of architectural plans and narrative shall require that the proposed construction project is designed and constructed in accord with applicable statutory and other regulatory requirements. In performing a construction permit review for a health facility or agency under this section, the department shall, at a minimum, apply the standards contained in the document entitled "Minimum Design Standards for Health Care Facilities in Michigan" published by the department and dated March 1998. The standards are incorporated by reference for purposes of this subsection. The department may promulgate rules that are more stringent than the standards if necessary to protect the public health, safety, and welfare.

(7) The department shall promulgate rules to further prescribe the scope of construction projects and other alterations subject to review under this section.

(8) The department may waive the applicability of this section to a construction project or alteration if the waiver will not affect the public health, safety, and welfare.

(9) Upon request by the person initiating a construction project, the department may review and issue a construction permit to a construction project that is not subject to subsection (1) or (2) if the department determines that the review will promote the public health, safety, and welfare.

(10) The department shall assess a fee for each review conducted under this section. The fee is .5% of the first \$1,000,000.00 of capital expenditure and .85% of any amount over \$1,000,000.00 of capital expenditure, up to a maximum of \$60,000.00.

(11) As used in this section, "capital expenditure" means that term as defined in section 22203(2), except that it does not include the cost of equipment that is not fixed equipment.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 331, Imd. Eff. Dec. 21, 1990;—Am. 1991, Act 13, Imd. Eff. Apr. 25, 1991;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 683, Imd. Eff. Dec. 30, 2002;—Am. 2004, Act 469, Imd. Eff. Dec. 28, 2004.

Popular name: Act 368

Administrative rules: R 325.3801 et seq. and R 325.20101 et seq. of the Michigan Administrative Code.

333.20151 Cooperation; professional advice and consultation.

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Sec. 20151. A licensee or certificate holder shall cooperate with the department in carrying out its responsibility under this article. The department shall, to the extent allowed by law, provide professional advice and consultation as to the quality of facility or agency aspects of health care and services provided by the applicant or licensee.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 2000, Act 171, Imd. Eff. June 20, 2000.

Popular name: Act 368

333.20152 Certification by licensee; developing facilities and programs of care; rating individuals for purposes of reimbursement.

Sec. 20152. (1) A licensee shall certify to the department as part of its application for licensing and certification, that:

(a) All phases of its operation, including its training programs, comply with state and federal laws prohibiting discrimination. The applicant shall direct the administrator of the health facility or agency to take the necessary action to assure that the facility or agency is, in fact, so operated.

(b) Selection and appointment of physicians to its medical staff is without discrimination on the basis of licensure or registration as doctors of medicine or doctors of osteopathic medicine and surgery.

(2) This section does not prohibit a health facility or agency from developing facilities and programs of care that are for specific ages or sexes or rating individuals for purposes of determining appropriate reimbursement for care and services.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1981, Act 111, Imd. Eff. July 17, 1981.

Popular name: Act 368

333.20153 Definitions; single-use device; reusing, recycling, or refurbishing prohibited; exceptions; violation as felony; penalty.

Sec. 20153. (1) As used in this section:

(a) "Health care provider" means a health facility or agency or a health professional that utilizes single-use devices in furnishing medical or surgical treatment or care to human patients.

(b) "Health professional" means an individual licensed, certified, or authorized to engage in a health profession under article 15, but not including dentists, dental hygienists, or dental assistants under part 166 or veterinarians or veterinary technicians under part 188.

(c) "Original device" means a new, unused single-use device.

(d) "Reprocessed" means with respect to a single-use device, an original device that has previously been used on a human patient and has been subjected to additional processing and manufacturing for the purpose of additional use on a different human patient. Reprocessed includes the subsequent processing and manufacture of a reprocessed single-use device and any single-use device that meets the definition in this subdivision without regard to any description of the device used by the manufacturer of the device or other persons, including a description that uses the term "recycled", "refurbished", or "reused" rather than the term "reprocessed". Reprocessed does not include a disposable or single-use device that has been opened but not used on a person.

(e) "Single-use device" means a medical device that is intended for 1 use or procedure on a human patient, including any device marked "single-use device".

(2) Except as otherwise provided in this section, a health care provider shall not knowingly reuse, recycle, refurbish for reuse, or provide for reuse a single-use device.

(3) This section does not apply to a health care provider that does any of the following:

(a) Utilizes, recycles or reprocesses for utilization, or provides for utilization a single-use device that has been reprocessed by an entity that is registered as a reprocessor and is regulated by the United States food and drug administration.

(b) Utilizes an opened, but unused single-use device for which the sterility has been breached or compromised and that meets all of the following requirements:

(i) The single-use device has not been used on a human patient and has not been in contact with blood or bodily fluids.

(ii) The single-use device has been resterilized.

(c) Utilizes a used single-use device on the same human patient in an emergency situation.

(4) A health care provider that violates this section is guilty of a felony punishable by imprisonment for not more than 10 years or a fine of not more than \$50,000.00, or both. A violation of this section by a health professional is considered a violation of article 15 and that health professional is subject to administrative action under sections 16221(h) and 16226.

History: Add. 2010, Act 25, Imd. Eff. Mar. 26, 2010.

Popular name: Act 368

333.20155 Visits to health facilities and agencies, clinical laboratories, nursing homes, hospices, and hospitals; purposes; waiver; confidentiality of accreditation information; limitation and effect; consultation engineering survey; summary of substantial noncompliance or deficiencies and hospital response; investigations or inspections; prior notice; misdemeanor; consultation visits; record; periodic reports; access to documents; confidentiality; disclosure; delegation of functions; voluntary inspections; forwarding evidence of violation to licensing agency; reports; clarification of terms; clinical process guidelines; clinical advisory committee; definitions.

Sec. 20155. (1) Except as otherwise provided in this section, the department shall make annual and other visits to each health facility or agency licensed under this article for the purposes of survey, evaluation, and consultation. A visit made pursuant to a complaint shall be unannounced. Except for a county medical care facility, a home for the aged, a nursing home, or a hospice residence, the department shall determine whether the visits that are not made pursuant to a complaint are announced or unannounced. Beginning June 20, 2001, the department shall assure that each newly hired nursing home surveyor, as part of his or her basic training, is assigned full-time to a licensed nursing home for at least 10 days within a 14-day period to observe actual operations outside of the survey process before the trainee begins oversight responsibilities. A member of a survey team shall not be employed by a licensed nursing home or a nursing home management company doing business in this state at the time of conducting a survey under this section. The department shall not assign an individual to be a member of a survey team for purposes of a survey, evaluation, or consultation visit at a nursing home in which he or she was an employee within the preceding 5 years.

(2) The department shall make at least a biennial visit to each licensed clinical laboratory, each nursing home, and each hospice residence for the purposes of survey, evaluation, and consultation. The department shall semiannually provide for joint training with nursing home surveyors and providers on at least 1 of the 10 most frequently issued federal citations in this state during the past calendar year. The department shall develop a protocol for the review of citation patterns compared to regional outcomes and standards and complaints regarding the nursing home survey process. The review will result in a report provided to the legislature. Except as otherwise provided in this subsection, beginning with his or her first full relicensure period after June 20, 2000, each member of a department nursing home survey team who is a health professional licensee under article 15 shall earn not less than 50% of his or her required continuing education credits, if any, in geriatric care. If a member of a nursing home survey team is a pharmacist licensed under article 15, he or she shall earn not less than 30% of his or her required continuing education credits in geriatric care.

(3) The department shall make a biennial visit to each hospital for survey and evaluation for the purpose of licensure. Subject to subsection (6), the department may waive the biennial visit required by this subsection if a hospital, as part of a timely application for license renewal, requests a waiver and submits both of the following and if all of the requirements of subsection (5) are met:

(a) Evidence that it is currently fully accredited by a body with expertise in hospital accreditation whose hospital accreditations are accepted by the United States department of health and human services for purposes of section 1865 of part C of title XVIII of the social security act, 42 USC 1395bb.

(b) A copy of the most recent accreditation report for the hospital issued by a body described in subdivision (a), and the hospital's responses to the accreditation report.

(4) Except as provided in subsection (8), accreditation information provided to the department under subsection (3) is confidential, is not a public record, and is not subject to court subpoena. The department shall use the accreditation information only as provided in this section and shall return the accreditation information to the hospital within a reasonable time after a decision on the waiver request is made.

(5) The department shall grant a waiver under subsection (3) if the accreditation report submitted under subsection (3)(b) is less than 2 years old and there is no indication of substantial noncompliance with licensure standards or of deficiencies that represent a threat to public safety or patient care in the report, in complaints involving the hospital, or in any other information available to the department. If the accreditation report is 2 or more years old, the department may do 1 of the following:

(a) Grant an extension of the hospital's current license until the next accreditation survey is completed by the body described in subsection (3)(a).

(b) Grant a waiver under subsection (3) based on the accreditation report that is 2 or more years old, on condition that the hospital promptly submit the next accreditation report to the department.

(c) Deny the waiver request and conduct the visits required under subsection (3).

(6) This section does not prohibit the department from citing a violation of this part during a survey, conducting investigations or inspections pursuant to section 20156, or conducting surveys of health facilities or agencies for the purpose of complaint investigations or federal certification. This section does not prohibit the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, from conducting annual surveys of hospitals, nursing homes, and county medical care facilities.

(7) At the request of a health facility or agency, the department may conduct a consultation engineering survey of a health facility and provide professional advice and consultation regarding health facility construction and design. A health facility or agency may request a voluntary consultation survey under this subsection at any time between licensure surveys. The fees for a consultation engineering survey are the same as the fees established for waivers under section 20161(10).

(8) If the department determines that substantial noncompliance with licensure standards exists or that deficiencies that represent a threat to public safety or patient care exist based on a review of an accreditation report submitted pursuant to subsection (3)(b), the department shall prepare a written summary of the substantial noncompliance or deficiencies and the hospital's response to the department's determination. The department's written summary and the hospital's response are public documents.

(9) The department or a local health department shall conduct investigations or inspections, other than inspections of financial records, of a county medical care facility, home for the aged, nursing home, or hospice residence without prior notice to the health facility or agency. An employee of a state agency charged with investigating or inspecting the health facility or agency or an employee of a local health department who directly or indirectly gives prior notice regarding an investigation or an inspection, other than an inspection of the financial records, to the health facility or agency or to an employee of the health facility or agency, is guilty of a misdemeanor. Consultation visits that are not for the purpose of annual or follow-up inspection or survey may be announced.

(10) The department shall maintain a record indicating whether a visit and inspection is announced or unannounced. Information gathered at each visit and inspection, whether announced or unannounced, shall be taken into account in licensure decisions.

(11) The department shall require periodic reports and a health facility or agency shall give the department access to books, records, and other documents maintained by a health facility or agency to the extent necessary to carry out the purpose of this article and the rules promulgated under this article. The department shall respect the confidentiality of a patient's clinical record and shall not divulge or disclose the contents of the records in a manner that identifies an individual except under court order. The department may copy health facility or agency records as required to document findings.

(12) The department may delegate survey, evaluation, or consultation functions to another state agency or to a local health department qualified to perform those functions. However, the department shall not delegate survey, evaluation, or consultation functions to a local health department that owns or operates a hospice or hospice residence licensed under this article. The delegation shall be by cost reimbursement contract between the department and the state agency or local health department. Survey, evaluation, or consultation functions shall not be delegated to nongovernmental agencies, except as provided in this section. The department may accept voluntary inspections performed by an accrediting body with expertise in clinical laboratory accreditation under part 205 if the accrediting body utilizes forms acceptable to the department, applies the same licensing standards as applied to other clinical laboratories, and provides the same information and data usually filed by the department's own employees when engaged in similar inspections or surveys. The voluntary inspection described in this subsection shall be agreed upon by both the licensee and the department.

(13) If, upon investigation, the department or a state agency determines that an individual licensed to practice a profession in this state has violated the applicable licensure statute or the rules promulgated under that statute, the department, state agency, or local health department shall forward the evidence it has to the appropriate licensing agency.

(14) The department shall report to the appropriations subcommittees, the senate and house of representatives standing committees having jurisdiction over issues involving senior citizens, and the fiscal agencies on March 1 of each year on the initial and follow-up surveys conducted on all nursing homes in this state. The report shall include all of the following information:

- (a) The number of surveys conducted.
- (b) The number requiring follow-up surveys.
- (c) The number referred to the Michigan public health institute for remediation.
- (d) The number of citations per nursing home.
- (e) The number of night and weekend complaints filed.

- (f) The number of night and weekend responses to complaints conducted by the department.
- (g) The average length of time for the department to respond to a complaint filed against a nursing home.
- (h) The number and percentage of citations appealed.
- (i) The number and percentage of citations overturned or modified, or both.

(15) The department shall report annually to the standing committees on appropriations and the standing committees having jurisdiction over issues involving senior citizens in the senate and the house of representatives on the percentage of nursing home citations that are appealed and the percentage of nursing home citations that are appealed and amended through the informal deficiency dispute resolution process.

(16) Subject to subsection (17), a clarification work group comprised of the department in consultation with a nursing home resident or a member of a nursing home resident's family, nursing home provider groups, the American medical directors association, the state long-term care ombudsman, and the federal centers for medicare and medicaid services shall clarify the following terms as those terms are used in title XVIII and title XIX and applied by the department to provide more consistent regulation of nursing homes in Michigan:

- (a) Immediate jeopardy.
- (b) Harm.
- (c) Potential harm.
- (d) Avoidable.
- (e) Unavoidable.

(17) All of the following clarifications developed under subsection (16) apply for purposes of subsection (16):

(a) Specifically, the term "immediate jeopardy" means a situation in which immediate corrective action is necessary because the nursing home's noncompliance with 1 or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident receiving care in a nursing home.

(b) The likelihood of immediate jeopardy is reasonably higher if there is evidence of a flagrant failure by the nursing home to comply with a clinical process guideline adopted under subsection (18) than if the nursing home has substantially and continuously complied with those guidelines. If federal regulations and guidelines are not clear, and if the clinical process guidelines have been recognized, a process failure giving rise to an immediate jeopardy may involve an egregious widespread or repeated process failure and the absence of reasonable efforts to detect and prevent the process failure.

(c) In determining whether or not there is immediate jeopardy, the survey agency should consider at least all of the following:

(i) Whether the nursing home could reasonably have been expected to know about the deficient practice and to stop it, but did not stop the deficient practice.

(ii) Whether the nursing home could reasonably have been expected to identify the deficient practice and to correct it, but did not correct the deficient practice.

(iii) Whether the nursing home could reasonably have been expected to anticipate that serious injury, serious harm, impairment, or death might result from continuing the deficient practice, but did not so anticipate.

(iv) Whether the nursing home could reasonably have been expected to know that a widely accepted high-risk practice is or could be problematic, but did not know.

(v) Whether the nursing home could reasonably have been expected to detect the process problem in a more timely fashion, but did not so detect.

(d) The existence of 1 or more of the factors described in subdivision (c), and especially the existence of 3 or more of those factors simultaneously, may lead to a conclusion that the situation is one in which the nursing home's practice makes adverse events likely to occur if immediate intervention is not undertaken, and therefore constitutes immediate jeopardy. If none of the factors described in subdivision (c) is present, the situation may involve harm or potential harm that is not immediate jeopardy.

(e) Specifically, "actual harm" means a negative outcome to a resident that has compromised the resident's ability to maintain or reach, or both, his or her highest practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. Harm does not include a deficient practice that only may cause or has caused limited consequences to the resident.

(f) For purposes of subdivision (e), in determining whether a negative outcome is of limited consequence, if the "state operations manual" or "the guidance to surveyors" published by the federal centers for medicare and medicaid services does not provide specific guidance, the department may consider whether most people in similar circumstances would feel that the damage was of such short duration or impact as to be inconsequential or trivial. In such a case, the consequence of a negative outcome may be considered more limited if it occurs in the context of overall procedural consistency with an accepted clinical process guideline

adopted pursuant to subsection (18), as compared to a substantial inconsistency with or variance from the guideline.

(g) For purposes of subdivision (e), if the publications described in subdivision (f) do not provide specific guidance, the department may consider the degree of a nursing home's adherence to a clinical process guideline adopted pursuant to subsection (18) in considering whether the degree of compromise and future risk to the resident constitutes actual harm. The risk of significant compromise to the resident may be considered greater in the context of substantial deviation from the guidelines than in the case of overall adherence.

(h) To improve consistency and to avoid disputes over avoidable and unavoidable negative outcomes, nursing homes and survey agencies must have a common understanding of accepted process guidelines and of the circumstances under which it can reasonably be said that certain actions or inactions will lead to avoidable negative outcomes. If the "state operations manual" or "the guidance to surveyors" published by the federal centers for medicare and medicaid services is not specific, a nursing home's overall documentation of adherence to a clinical process guideline with a process indicator adopted pursuant to subsection (18) is relevant information in considering whether a negative outcome was avoidable or unavoidable and may be considered in the application of that term.

(18) Subject to subsection (19), the department, in consultation with the clarification work group appointed under subsection (16), shall develop and adopt clinical process guidelines that shall be used in applying the terms set forth in subsection (16). The department shall establish and adopt clinical process guidelines and compliance protocols with outcome measures for all of the following areas and for other topics where the department determines that clarification will benefit providers and consumers of long-term care:

- (a) Bed rails.
- (b) Adverse drug effects.
- (c) Falls.
- (d) Pressure sores.
- (e) Nutrition and hydration including, but not limited to, heat-related stress.
- (f) Pain management.
- (g) Depression and depression pharmacotherapy.
- (h) Heart failure.
- (i) Urinary incontinence.
- (j) Dementia.
- (k) Osteoporosis.
- (l) Altered mental states.
- (m) Physical and chemical restraints.

(19) The department shall create a clinical advisory committee to review and make recommendations regarding the clinical process guidelines with outcome measures adopted under subsection (18). The department shall appoint physicians, registered professional nurses, and licensed practical nurses to the clinical advisory committee, along with professionals who have expertise in long-term care services, some of whom may be employed by long-term care facilities. The clarification work group created under subsection (16) shall review the clinical process guidelines and outcome measures after the clinical advisory committee and shall make the final recommendations to the department before the clinical process guidelines are adopted.

(20) The department shall create a process by which the director of the division of nursing home monitoring or his or her designee or the director of the division of operations or his or her designee reviews and authorizes the issuance of a citation for immediate jeopardy or substandard quality of care before the statement of deficiencies is made final. The review shall be to assure that the applicable concepts, clinical process guidelines, and other tools contained in subsections (17) to (19) are being used consistently, accurately, and effectively. As used in this subsection, "immediate jeopardy" and "substandard quality of care" mean those terms as defined by the federal centers for medicare and medicaid services.

(21) The department may give grants, awards, or other recognition to nursing homes to encourage the rapid implementation of the clinical process guidelines adopted under subsection (18).

(22) The department shall assess the effectiveness of 2001 PA 218. The department shall file an annual report on the implementation of the clinical process guidelines and the impact of the guidelines on resident care with the standing committee in the legislature with jurisdiction over matters pertaining to nursing homes. The first report shall be filed on July 1, 2002.

(23) The department shall instruct and train the surveyors in the use of the clarifications described in subsection (17) and the clinical process guidelines adopted under subsection (18) in citing deficiencies.

(24) A nursing home shall post the nursing home's survey report in a conspicuous place within the nursing

home for public review.

(25) Nothing in this amendatory act shall be construed to limit the requirements of related state and federal law.

(26) As used in this section:

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

(b) "Title XIX" means title XIX of the social security act, chapter 531, 42 USC 1396 to 1396v.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1981, Act 111, Imd. Eff. July 17, 1981;—Am. 1982, Act 474, Eff. Mar. 30, 1983;—Am. 1992, Act 80, Imd. Eff. June 2, 1992;—Am. 1996, Act 267, Imd. Eff. June 12, 1996;—Am. 2000, Act 170, Imd. Eff. June 20, 2000;—Am. 2000, Act 171, Imd. Eff. June 20, 2000;—Am. 2001, Act 218, Imd. Eff. Dec. 28, 2001;—Am. 2006, Act 195, Imd. Eff. June 19, 2006.

Compiler's note: For transfer of the clinical advisory committee to the department of community health, and abolishment of the committee, see E.R.O. No. 2009-6, compiled at MCL 333.26329.

Popular name: Act 368

Administrative rules: R 325.3801 et seq. of the Michigan Administrative Code.

333.20156 Entering premises of applicant or licensee; enforcement of rules; certificate of approval from bureau of fire services; applicability of subsections (2) and (3).

Sec. 20156. (1) A representative of the department or the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, upon presentation of proper identification, may enter the premises of an applicant or licensee at any reasonable time to determine whether the applicant or licensee meets the requirements of this article and the rules promulgated under this article. The director; the director of the department of human services; the bureau of fire services; the director of the office of services to the aging; or the director of a local health department; or an authorized representative of the director, the director of the department of human services, the bureau of fire services, the director of the office of services to the aging, or the director of a local health department may enter on the premises of an applicant or licensee under part 217 at any time in the course of carrying out program responsibilities.

(2) The bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, shall enforce rules promulgated by the bureau of fire services for health facilities and agencies to assure that physical facilities owned, maintained, or operated by a health facility or agency are planned, constructed, and maintained in a manner to protect the health, safety, and welfare of patients.

(3) The department shall not issue a license or certificate to a health facility or agency until it receives an appropriate certificate of approval from the bureau of fire services. For purposes of this section, a decision of the bureau of fire services to issue a certificate controls over that of a local fire department.

(4) Subsections (2) and (3) do not apply to a health facility or an agency licensed under part 205 or 209.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1982, Act 474, Eff. Mar. 30, 1983;—Am. 1986, Act 78, Imd. Eff. Apr. 7, 1986;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2006, Act 195, Imd. Eff. June 19, 2006.

Compiler's note: For transfer of powers and duties of the fire marshal division on programs relating to fire safety inspections of adult foster care, correctional, and health care facilities from the department of state police to the department of consumer and industry services, see E.R.O. No. 1997-2, compiled at MCL 29.451 of the Michigan Compiled Laws.

Popular name: Act 368

333.20161 Fees and assessments for health facility and agency licenses and certificates of need; reimbursement rates; use of quality assurance assessment; tax levy; "medicaid" defined.

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. Except as otherwise provided in this article, fees and assessments shall be paid in accordance with the following schedule:

- (a) Freestanding surgical outpatient facilities.....\$238.00 per facility.
- (b) Hospitals.....\$8.28 per licensed bed.
- (c) Nursing homes, county medical care facilities, and hospital long-term care units.....\$2.20 per licensed bed.
- (d) Homes for the aged.....\$6.27 per licensed bed.
- (e) Clinical laboratories.....\$475.00 per laboratory.
- (f) Hospice residences.....\$200.00 per license survey; and \$20.00 per licensed bed.

(g) Subject to subsection

(13), quality assurance assessment
for nursing homes and hospital
long-term care units.....an amount resulting
in not more than 6%
of total industry
revenues.

(h) Subject to subsection
(14), 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
(14)(a) and (i).

(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) The base fee for a certificate of need is \$1,500.00 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 \$4,000.00 shall be added to the base fee. For a project requiring a projected capital expenditure of \$4,000,000.00 or more, an additional fee of \$7,000.00 shall be added to the base fee. The department of community health 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) If licensure is for more than 1 year, the fees described in subsection (1) are multiplied by the number of years for which the license is issued, and the total amount of the fees shall be collected in the year in which the license is issued.

(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 department may charge a fee to recover the cost of purchase or production and distribution of proficiency evaluation samples that are supplied to clinical laboratories pursuant to section 20521(3).

(8) In addition to the fees imposed under subsection (1), a clinical laboratory shall submit a fee of \$25.00 to the department for each reissuance during the licensure period of the clinical laboratory's license.

(9) The cost of licensure activities shall be supported by license fees.

(10) 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.

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

(12) 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.

(13) The quality assurance assessment collected under subsection (1)(g) 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) in accordance with subdivision (c)(i) or in accordance with a written payment agreement with the 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 pursuant to subdivision (f) have been paid in full. Nothing in this subdivision shall be construed to 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 nonmedicare patients within the immediately preceding year and 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, 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 pursuant 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 nonmedicare patient day of care provided within the immediately preceding year or a rate as otherwise altered on the application for the waiver to obtain federal approval. If the waiver is approved, for all other nursing homes and long-term care units the quality assurance assessment rate is to be calculated by dividing the total statewide maximum allowable assessment permitted under subsection (1)(g) less the total amount to be paid by the nursing homes and long-term care units with less than 40 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 nonmedicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39, 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, 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 of community health 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 of community health shall maintain the medicaid nursing home reimbursement payment increase financed by the quality assurance assessment.

(e) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment qualifies for federal matching funds.

(f) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection (1)(g), the department of community health 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 of community health 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 of community health 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 of community health 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) 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).

(k) The state retention amount of the quality assurance assessment collected pursuant to subsection (1)(g) 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 of community health 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, 2015, the department shall no longer assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection (1)(g) shall no longer be assessed or collected after September 30, 2011, in the event that 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.

(14) The quality assurance dedication is an earmarked assessment collected under subsection (1)(h). 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, 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 of community health 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 of community health shall maintain the hospital medicaid reimbursement rate increase financed by the quality assurance assessments.

(d) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment qualifies for federal matching funds.

(e) If a hospital fails to pay the assessment required by subsection (1)(h), the department of community health 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 of community health 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 of community health 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), except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection (1)(h) shall no longer be assessed or collected after September 30, 2011 in the event that 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 pursuant to subsection (1)(h) shall be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. 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 of community health 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.

(15) The quality assurance assessment provided for under this section is a tax that is levied on a health

facility or agency.

(16) As used in this section, "medicaid" means that term as defined in section 22207.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1981, Act 76, Eff. Oct. 1, 1981;—Am. 1984, Act 376, Eff. Mar. 29, 1985;—Am. 1987, Act 217, Imd. Eff. Dec. 22, 1987;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1990, Act 252, Imd. Eff. Oct. 12, 1990;—Am. 1996, Act 267, Imd. Eff. June 12, 1996;—Am. 2000, Act 253, Imd. Eff. June 29, 2000;—Am. 2002, Act 303, Imd. Eff. May 10, 2002;—Am. 2002, Act 562, Imd. Eff. Oct. 1, 2002;—Am. 2003, Act 113, Imd. Eff. July 24, 2003;—Am. 2003, Act 234, Imd. Eff. Dec. 29, 2003;—Am. 2004, Act 393, Imd. Eff. Oct. 15, 2004;—Am. 2004, Act 469, Imd. Eff. Dec. 28, 2004;—Am. 2005, Act 187, Eff. Sept. 30, 2005;—Am. 2007, Act 5, Imd. Eff. Mar. 23, 2007;—Am. 2007, Act 85, Imd. Eff. Sept. 30, 2007;—Am. 2008, Act 173, Imd. Eff. July 2, 2008;—Am. 2008, Act 277, Imd. Eff. Sept. 29, 2008;—Am. 2011, Act 144, Imd. Eff. Sept. 21, 2011.

Compiler's note: Enacting section 2 of Act 234 of 2003 provides:

"Enacting section 2. (1) Section 20161 as amended by this amendatory act is curative and intended to express the original intent of the legislature regarding the application of 2002 PA 303 and 2002 PA 562, as amended by 2003 PA 113.

"(2) Section 20161 as amended by this amendatory act is retroactive and is effective for all quality assurance assessments made after May 9, 2002."

Enacting section 1 of Act 187 of 2005 provides:

"Enacting section 1. Section 20161 of the public health code, 1978 PA 368, MCL 333.20161, as amended by this amendatory act is retroactive and is effective for all quality assurance assessments made after September 30, 2005."

Popular name: Act 368

Administrative rules: R 325.3801 et seq. of the Michigan Administrative Code.

333.20162 License; receipt of completed application; issuance of license within certain period of time; nonrenewable temporary permit; provisional license; procedure for closing facility; order to licensee upon finding of noncompliance; notice, hearing, and status requirements; report; "completed application" defined.

Sec. 20162. (1) Beginning on the effective date of the amendatory act that added section 20935, upon a determination that a health facility or agency is in compliance with this article and the rules promulgated under this article, the department shall issue an initial license within 6 months after the applicant files a completed application. Receipt of the application is considered the date the application is received by any agency or department of this state. If the application is considered incomplete by the department, the department shall notify the applicant in writing or make the notice electronically available within 30 days after receipt of the incomplete application, describing the deficiency and requesting additional information. If the department identifies a deficiency or requires the fulfillment of a corrective action plan, the 6-month period is tolled until either of the following occurs:

(a) Upon notification by the department of a deficiency, until the date the requested information is received by the department.

(b) Upon notification by the department that a corrective action plan is required, until the date the department determines the requirements of the corrective action plan have been met.

(2) The determination of the completeness of an application does not operate as an approval of the application for the license and does not confer eligibility of an applicant determined otherwise ineligible for issuance of a license.

(3) Except as otherwise provided in this subsection, if the department fails to issue or deny a license within the time period required by this section, the department shall return the license fee and shall reduce the license fee for the applicant's next licensure application, if any, by 15%. Failure to issue or deny a license within the time period required under this section does not allow the department to otherwise delay processing an application. The completed application shall be placed in sequence with other completed applications received at that same time. The department shall not discriminate against an applicant in the processing of the application based upon the fact that the application fee was refunded or discounted under this subsection. The department may issue a nonrenewable temporary permit for not more than 6 months if additional time is needed to make a proper investigation or to permit the applicant to undertake remedial action related to operational or procedural deficiencies or items of noncompliance. A temporary permit shall not be issued to cover deficiencies in physical plant requirements.

(4) Except as provided in part 217, the department may issue a provisional license for not more than 3 consecutive years to an applicant who temporarily is unable to comply with the rules as to the physical plant owned, maintained, or operated by a health facility or agency except as otherwise provided in this article. A provisional license shall not be issued to a new health facility or agency or a facility or agency whose ownership is transferred after September 30, 1978, unless the facility or agency was licensed and operating under this article or a prior law for not less than 5 years. Provisional licensure under acts repealed by this code shall be counted against the 3-year maximum for licensure.

(5) The department, in order to protect the people of this state, shall provide a procedure for the orderly closing of a facility if it is unable to maintain its license under this section.

(6) Except as provided in part 217, the department, upon finding that a health facility or agency is not operating in accord with the requirements of its license, may:

(a) Issue an order directing the licensee to:

(i) Discontinue admissions.

(ii) Transfer selected patients out of the facility.

(iii) Reduce its licensed capacity.

(iv) Comply with specific requirements for licensure or certification as appropriate.

(b) Through the office of the attorney general, initiate misdemeanor proceedings against the licensee as provided in section 20199(1).

(7) An order issued under subsection (6) shall be governed by the notice and hearing requirements of section 20168(1) and the status requirements of section 20168(2).

(8) Beginning October 1, 2005, the director of the department shall submit a report by December 1 of each year to the standing committees and appropriations subcommittees of the senate and house of representatives concerned with public health issues. The director shall include all of the following information in the report concerning the preceding fiscal year:

(a) The number of initial applications the department received and completed within the 6-month time period required under subsection (1).

(b) The number of applications requiring a request for additional information.

(c) The number of applications denied.

(d) The average processing time for initial licenses granted after the 6-month period.

(e) The number of temporary permits issued under subsection (3).

(f) The number of initial license applications not issued within the 6-month period and the amount of money returned to applicants under subsection (3).

(9) As used in this section, "completed application" means an application complete on its face and submitted with any applicable licensing fees as well as any other information, records, approval, security, or similar item required by law or rule from a local unit of government, a federal agency, or a private entity but not from another department or agency of this state.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2004, Act 284, Imd. Eff. July 23, 2004.

Popular name: Act 368

333.20164 Duration of license or certification; license, certification, or certificate of need nontransferable; transfer of ownership or ownership interest; notice; application for license and certification.

Sec. 20164. (1) A license, certification, provisional license, or limited license is valid for not more than 1 year after the date of issuance, except as provided in section 20511 or part 209 or 210. A license for a facility licensed under part 215 shall be valid for 2 years, except that provisional and limited licenses may be valid for 1 year.

(2) A license, certification, or certificate of need is not transferable and shall state the persons, buildings, and properties to which it applies. Applications for licensure or certification because of transfer of ownership or essential ownership interest shall not be acted upon until satisfactory evidence is provided of compliance with part 222.

(3) If ownership is not voluntarily transferred, the department shall be notified immediately and the new owner shall apply for a license and certification not later than 30 days after the transfer.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1981, Act 111, Imd. Eff. July 17, 1981;—Am. 1982, Act 474, Eff. Mar. 30, 1983;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20165 Denying, limiting, suspending, or revoking license or certification; notice of intent; imposition of administrative fine.

Sec. 20165. (1) Except as otherwise provided in this section, after notice of intent to an applicant or licensee to deny, limit, suspend, or revoke the applicant's or licensee's license or certification and an opportunity for a hearing, the department may deny, limit, suspend, or revoke the license or certification or impose an administrative fine on a licensee if 1 or more of the following exist:

(a) Fraud or deceit in obtaining or attempting to obtain a license or certification or in the operation of the licensed health facility or agency.

- (b) A violation of this article or a rule promulgated under this article.
 - (c) False or misleading advertising.
 - (d) Negligence or failure to exercise due care, including negligent supervision of employees and subordinates.
 - (e) Permitting a license or certificate to be used by an unauthorized health facility or agency.
 - (f) Evidence of abuse regarding a patient's health, welfare, or safety or the denial of a patient's rights.
 - (g) Failure to comply with section 10115.
 - (h) Failure to comply with part 222 or a term, condition, or stipulation of a certificate of need issued under part 222, or both.
 - (i) A violation of section 20197(1).
- (2) The department may deny an application for a license or certification based on a finding of a condition or practice that would constitute a violation of this article if the applicant were a licensee.
- (3) Denial, suspension, or revocation of an individual emergency medical services personnel license under part 209 is governed by section 20958.
- (4) If the department determines under subsection (1) that a health facility or agency has violated section 20197(1), the department shall impose an administrative fine of \$5,000,000.00 on the health facility or agency.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1986, Act 186, Eff. Oct. 7, 1986;—Am. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1998, Act 108, Eff. Mar. 23, 1999;—Am. 2008, Act 39, Eff. May 1, 2008.

Popular name: Act 368

333.20166 Notice of intent to deny, limit, suspend, or revoke license or certification; service; contents; hearing; record; transcript; determination; powers of department; judicial order to appear and give testimony; contempt; failure to show need for health facility or agency.

Sec. 20166. (1) Notice of intent to deny, limit, suspend, or revoke a license or certification shall be given by certified mail or personal service, shall set forth the particular reasons for the proposed action, and shall fix a date, not less than 30 days after the date of service, on which the applicant or licensee shall be given the opportunity for a hearing before the director or the director's authorized representative. The hearing shall be conducted in accordance with the administrative procedures act of 1969 and rules promulgated by the department. A full and complete record shall be kept of the proceeding and shall be transcribed when requested by an interested party, who shall pay the cost of preparing the transcript.

(2) On the basis of a hearing or on the default of the applicant or licensee, the department may issue, deny, limit, suspend, or revoke a license or certification. A copy of the determination shall be sent by certified mail or served personally upon the applicant or licensee. The determination becomes final 30 days after it is mailed or served, unless the applicant or licensee within the 30 days appeals the decision to the circuit court in the county of jurisdiction or to the Ingham county circuit court.

(3) The department may establish procedures, hold hearings, administer oaths, issue subpoenas, or order testimony to be taken at a hearing or by deposition in a proceeding pending at any stage of the proceeding. A person may be compelled to appear and testify and to produce books, papers, or documents in a proceeding.

(4) In case of disobedience of a subpoena, a party to a hearing may invoke the aid of the circuit court of the jurisdiction in which the hearing is held to require the attendance and testimony of witnesses. The circuit court may issue an order requiring an individual to appear and give testimony. Failure to obey the order of the circuit court may be punished by the court as a contempt.

(5) The department shall not deny, limit, suspend, or revoke a license on the basis of an applicant's or licensee's failure to show a need for a health facility or agency unless the health facility or agency has not obtained a certificate of need required by part 222.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1988, Act 332, Eff. Oct. 1, 1988.

Compiler's note: In paragraph (1), the words "not less than 30 days" evidently should read "not less than 30 days."

Popular name: Act 368

333.20168 Emergency order limiting, suspending, or revoking license; limiting reimbursements or payments; hearing; contents of order; order not suspended by hearing.

Sec. 20168. (1) Upon a finding that a deficiency or violation of this article or the rules promulgated under this article seriously affects the health, safety, and welfare of individuals receiving care or services in or from a licensed health facility or agency, the department may issue an emergency order limiting, suspending, or revoking the license of the health facility or agency. If the department of public health issues an emergency

order affecting the license of a nursing home, the department of public health may request the department of social services to limit reimbursements or payments authorized under section 21718. The department shall provide an opportunity for a hearing within 5 working days after issuance of the order.

(2) An order shall incorporate the department's findings. The conduct of a hearing under this section shall not suspend the department's order.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20169 HIV infected test subject; compliance with reporting requirements; definitions.

Sec. 20169. (1) A health facility or agency licensed under this article that obtains from a test subject a test result that indicates that the test subject is HIV infected shall comply with the reporting requirements of section 5114.

(2) As used in this section:

(a) "HIV" means human immunodeficiency virus.

(b) "HIV infected" means that term as defined in section 5101.

History: Add. 1988, Act 489, Eff. Mar. 30, 1989.

Popular name: Act 368

333.20170 Medical records access; compliance.

Sec. 20170. A health facility or agency shall comply with the medical records access act.

History: Add. 2004, Act 48, Imd. Eff. Apr. 1, 2004.

Popular name: Act 368

333.20171 Rules implementing article; rules promulgated under MCL 333.21563.

Sec. 20171. (1) The department, after obtaining approval of the advisory commission, shall promulgate and enforce rules to implement this article, including rules necessary to enable a health facility or agency to qualify for and receive federal funds available for patient care or for projects involving new construction, additions, modernizations, or conversions.

(2) The rules applicable to health facilities or agencies shall be uniform insofar as is reasonable.

(3) The rules shall establish standards relating to:

(a) Ownership.

(b) Reasonable disclosure of ownership interests in proprietary corporations and of financial interests of trustees of voluntary, nonprofit corporations and owners of proprietary corporations and partnerships.

(c) Organization and function of the health facility or agency, owner, operator, and governing body.

(d) Administration.

(e) Professional and nonprofessional staff, services, and equipment appropriate to implement section 20141(3).

(f) Policies and procedures.

(g) Fiscal and medical audit.

(h) Utilization and quality control review.

(i) Physical plant including planning, construction, functional design, sanitation, maintenance, housekeeping, and fire safety.

(j) Arrangements for the continuing evaluation of the quality of health care provided.

(k) Other pertinent organizational, operational, and procedural requirements for each type of health facility or agency.

(4) The rules promulgated under section 21563 for the designation of rural community hospitals may also specify all of the following:

(a) Maximum bed size.

(b) The level of services to be provided in each category as described in section 21562(2).

(c) Requirements for transfer agreements with other hospitals to assure efficient and appropriate patient care.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

Administrative rules: R 325.1001 et seq.; R 325.1801 et seq.; R 325.2301 et seq.; R 325.3801 et seq.; R 325.6001 et seq.; R 325.20101 et seq.; and R 325.23101 et seq. of the Michigan Administrative Code.

333.20172 Policies and procedures; publication and distribution.

Sec. 20172. The department may publish and distribute written policies and procedures in the form of

departmental letters necessary to the effective administration of this article.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20173 Repealed. 2006, Act 28, Eff. Apr. 1, 2006.

Compiler's note: The repealed section pertained to criminal history check for employment applicants to nursing home, county medical care facility, or home for the aged.

333.20173a Covered facility; employees or applicants for employment; prohibitions; criminal history check; procedure; conditional employment; knowingly providing false information as misdemeanor; prohibited use or dissemination of criminal history information as misdemeanor; review by licensing or regulatory department; conditions of continued employment; failure to conduct criminal history checks as misdemeanor; establishment of automated fingerprint identification system database; electronic web-based system; definitions.

Sec. 20173a. (1) Except as otherwise provided in subsection (2), a covered facility shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility if the individual satisfies 1 or more of the following:

(a) Has been convicted of a relevant crime described under 42 USC 1320a-7(a).

(b) Has been convicted of any of the following felonies, an attempt or conspiracy to commit any of those felonies, or any other state or federal crime that is similar to the felonies described in this subdivision, other than a felony for a relevant crime described under 42 USC 1320a-7(a), unless 15 years have lapsed since the individual completed all of the terms and conditions of his or her sentencing, parole, and probation for that conviction prior to the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(i) A felony that involves the intent to cause death or serious impairment of a body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat of the use of force or violence.

(ii) A felony involving cruelty or torture.

(iii) A felony under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r.

(iv) A felony involving criminal sexual conduct.

(v) A felony involving abuse or neglect.

(vi) A felony involving the use of a firearm or dangerous weapon.

(vii) A felony involving the diversion or adulteration of a prescription drug or other medications.

(c) Has been convicted of a felony or an attempt or conspiracy to commit a felony, other than a felony for a relevant crime described under 42 USC 1320a-7(a) or a felony described under subdivision (b), unless 10 years have lapsed since the individual completed all of the terms and conditions of his or her sentencing, parole, and probation for that conviction prior to the date of application for employment or clinical privileges or the date of the execution of the independent contract.

(d) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the 10 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(i) A misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.

(ii) A misdemeanor under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r.

(iii) A misdemeanor involving criminal sexual conduct.

(iv) A misdemeanor involving cruelty or torture unless otherwise provided under subdivision (e).

(v) A misdemeanor involving abuse or neglect.

(e) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the 5 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:

(i) A misdemeanor involving cruelty if committed by an individual who is less than 16 years of age.

(ii) A misdemeanor involving home invasion.

- (iii) A misdemeanor involving embezzlement.
- (iv) A misdemeanor involving negligent homicide or a violation of section 601d(1) of the Michigan vehicle code, 1949 PA 300, MCL 257.601d.
- (v) A misdemeanor involving larceny unless otherwise provided under subdivision (g).
- (vi) A misdemeanor of retail fraud in the second degree unless otherwise provided under subdivision (g).
- (vii) Any other misdemeanor involving assault, fraud, theft, or the possession or delivery of a controlled substance unless otherwise provided under subdivision (d), (f), or (g).
- (f) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the 3 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:
 - (i) A misdemeanor for assault if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.
 - (ii) A misdemeanor of retail fraud in the third degree unless otherwise provided under subdivision (g).
 - (iii) A misdemeanor under part 74 unless otherwise provided under subdivision (g).
- (g) Has been convicted of any of the following misdemeanors, other than a misdemeanor for a relevant crime described under 42 USC 1320a-7(a), or a state or federal crime that is substantially similar to the misdemeanors described in this subdivision, within the year immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract:
 - (i) A misdemeanor under part 74 if the individual, at the time of conviction, is under the age of 18.
 - (ii) A misdemeanor for larceny or retail fraud in the second or third degree if the individual, at the time of conviction, is under the age of 16.
- (h) Is the subject of an order or disposition under section 16b of chapter IX of the code of criminal procedure, 1927 PA 175, MCL 769.16b.
- (i) Engages in conduct that becomes the subject of a substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 USC 1395i-3 or 1396r.

(2) Except as otherwise provided in this subsection or subsection (5), a covered facility shall not employ, independently contract with, or grant privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility until the covered facility or staffing agency has a criminal history check conducted in compliance with this section or has received criminal history record information in compliance with subsections (3) and (10). This subsection and subsection (1) do not apply to any of the following:

(a) An individual who is employed by, under independent contract to, or granted clinical privileges in a covered facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subdivision and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police with a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (13). An individual who is exempt under this subdivision is not limited to working within the covered facility with which he or she is employed by, under independent contract to, or granted clinical privileges on April 1, 2006 but may transfer to another covered facility, adult foster care facility, or mental health facility. If an individual who is exempt under this subdivision is subsequently convicted of a crime described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), then he or she is no longer exempt and shall be terminated from employment or denied employment or clinical privileges.

(b) An individual who is under an independent contract with a covered facility if he or she is not under the facility's control and the services for which he or she is contracted are not directly related to the provision of services to a patient or resident or if the services for which he or she is contracted allow for direct access to the patients or residents but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who is under an independent contract with the covered facility to provide utility, maintenance, construction, or communications services.

(3) An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a staffing agency or covered facility and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the applicant has been the subject of a criminal history check conducted in compliance with this section, the applicant shall give written consent at the time of

application for the covered facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) from the relevant licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (10) are not met and a request to the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the applicant is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the staffing agency or covered facility that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that applicant to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (10) are not met and a request to the federal bureau of investigation to make a subsequent determination of the existence of any national criminal history pertaining to the applicant is necessary, the covered facility or staffing agency shall proceed in the manner required in subsection (4). A staffing agency that employs an individual who regularly has direct access to or provides direct services to patients or residents under an independent contract with a covered facility shall submit information regarding the criminal history check conducted by the staffing agency to the covered facility that has made a good faith offer of independent contract to that applicant.

(4) Upon receipt of the written consent to conduct a criminal history check and identification required under subsection (3), a staffing agency or covered facility that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant shall make a request to the department of state police to conduct a criminal history check on the applicant, to input the applicant's fingerprints into the automated fingerprint identification system database, and to forward the applicant's fingerprints to the federal bureau of investigation. The department of state police shall request the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the applicant. The applicant shall provide the department of state police with a set of fingerprints. The request shall be made in a manner prescribed by the department of state police. The staffing agency or covered facility shall make the written consent and identification available to the department of state police. The staffing agency or covered facility shall make a request regarding that applicant to the relevant licensing or regulatory department to conduct a check of all relevant registries established pursuant to federal and state law and regulations for any substantiated findings of abuse, neglect, or misappropriation of property. If the department of state police or the federal bureau of investigation charges a fee for conducting the criminal history check, the staffing agency or covered facility shall pay the cost of the charge. If the department of state police or the federal bureau of investigation charges a fee for conducting the criminal history check, the department shall pay the cost of or reimburse the charge for a covered facility that is a home for the aged. The staffing agency or covered facility shall not seek reimbursement for a charge imposed by the department of state police or the federal bureau of investigation from the individual who is the subject of the criminal history check. A prospective employee or a prospective independent contractor covered under this section may not be charged for the cost of a criminal history check required under this section. The department of state police shall conduct a criminal history check on the applicant named in the request. The department of state police shall provide the department with a written report of the criminal history check conducted under this subsection. The report shall contain any criminal history record information on the applicant maintained by the department of state police. The department of state police shall provide the results of the federal bureau of investigation determination to the department within 30 days after the request is made. If the requesting staffing agency or covered facility is not a state department or agency and if criminal history record information is disclosed on the written report of the criminal history check or the federal bureau of investigation determination that resulted in a conviction, the department shall notify the staffing agency or covered facility and the applicant in writing of the type of crime disclosed on the written report of the criminal history check or the federal bureau of investigation determination without disclosing the details of the crime. Any charges imposed by the department of state police or the federal bureau of investigation for conducting a criminal history check or making a determination under this subsection shall be paid in the manner required under this subsection. The notice shall include a statement that the applicant has a right to appeal the information relied upon by the staffing agency or covered facility in making its decision regarding his or her employment eligibility based on the criminal history check. The notice shall also include information regarding where to file and describing the appellate procedures established under section 20173b.

(5) If a covered facility determines it necessary to employ or grant clinical privileges to an applicant before receiving the results of the applicant's criminal history check or criminal history record information under this section, the covered facility may conditionally employ or grant conditional clinical privileges to the individual

if all of the following apply:

(a) The covered facility requests the criminal history check or criminal history record information under this section upon conditionally employing or conditionally granting clinical privileges to the individual.

(b) The individual signs a statement in writing that indicates all of the following:

(i) That he or she has not been convicted of 1 or more of the crimes that are described in subsection (1)(a) to (g) within the applicable time period prescribed by each subdivision respectively.

(ii) That he or she is not the subject of an order or disposition described in subsection (1)(h).

(iii) That he or she has not been the subject of a substantiated finding as described in subsection (1)(i).

(iv) That he or she agrees that, if the information in the criminal history check conducted under this section does not confirm the individual's statements under subparagraphs (i) to (iii), his or her employment or clinical privileges will be terminated by the covered facility as required under subsection (1) unless and until the individual appeals and can prove that the information is incorrect.

(v) That he or she understands that the conditions described in subparagraphs (i) to (iv) may result in the termination of his or her employment or clinical privileges and that those conditions are good cause for termination.

(c) Except as otherwise provided in this subdivision, the covered facility does not permit the individual to have regular direct access to or provide direct services to patients or residents in the covered facility without supervision until the criminal history check or criminal history record information is obtained and the individual is eligible for that employment or clinical privileges. If required under this subdivision, the covered facility shall provide on-site supervision of an individual in the covered facility on a conditional basis under this subsection by an individual who has undergone a criminal history check conducted in compliance with this section. A covered facility may permit an individual in the covered facility on a conditional basis under this subsection to have regular direct access to or provide direct services to patients or residents in the covered facility without supervision if all of the following conditions are met:

(i) The covered facility, at its own expense and before the individual has direct access to or provides direct services to patients or residents of the covered facility, conducts a search of public records on that individual through the internet criminal history access tool maintained by the department of state police and the results of that search do not uncover any information that would indicate that the individual is not eligible to have regular direct access to or provide direct services to patients or residents under this section.

(ii) Before the individual has direct access to or provides direct services to patients or residents of the covered facility, the individual signs a statement in writing that he or she has resided in this state without interruption for at least the immediately preceding 12-month period.

(iii) If applicable, the individual provides to the department of state police a set of fingerprints on or before the expiration of 10 business days following the date the individual was conditionally employed or granted conditional clinical privileges under this subsection.

(6) The department shall develop and distribute a model form for the statements required under subsection (5)(b) and (c). The department shall make the model form available to covered facilities upon request at no charge.

(7) If an individual is employed as a conditional employee or is granted conditional clinical privileges under subsection (5), and the information under subsection (3) or report under subsection (4) does not confirm the individual's statement under subsection (5)(b)(i) to (iii), the covered facility shall terminate the individual's employment or clinical privileges as required by subsection (1).

(8) An individual who knowingly provides false information regarding his or her identity, criminal convictions, or substantiated findings on a statement described in subsection (5)(b)(i) to (iii) is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than \$500.00, or both.

(9) A staffing agency or covered facility shall use criminal history record information obtained under subsection (3) or (4) only for the purpose of evaluating an applicant's qualifications for employment, an independent contract, or clinical privileges in the position for which he or she has applied and for the purposes of subsections (5) and (7). A staffing agency or covered facility or an employee of the staffing agency or covered facility shall not disclose criminal history record information obtained under subsection (3) or (4) to a person who is not directly involved in evaluating the applicant's qualifications for employment, an independent contract, or clinical privileges. An individual who knowingly uses or disseminates the criminal history record information obtained under subsection (3) or (4) in violation of this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than \$1,000.00, or both. Except for a knowing or intentional release of false information, a staffing agency or covered facility has no liability in connection with a criminal history check conducted in compliance with this section or the release of criminal history record information under this subsection.

(10) Upon consent of an applicant as required in subsection (3) and upon request from a staffing agency or covered facility that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant, the relevant licensing or regulatory department shall review the criminal history record information, if any, and notify the requesting staffing agency or covered facility of the information in the manner prescribed in subsection (4). Until the federal bureau of investigation implements an automatic notification system similar to the system required of the state police under subsection (13) and federal regulations allow the federal criminal record to be used for subsequent authorized uses, as determined in an order issued by the department, a staffing agency or covered facility may rely on the criminal history record information provided by the relevant licensing or regulatory department under this subsection and a request to the federal bureau of investigation to make a subsequent determination of the existence of any national criminal history pertaining to the applicant is not necessary if all of the following requirements are met:

(a) The criminal history check was conducted during the immediately preceding 12-month period.

(b) The applicant has been continuously employed by the staffing agency or a covered facility, adult foster care facility, or mental health facility since the criminal history check was conducted in compliance with this section or meets the continuous employment requirement of this subdivision other than being on layoff status for less than 1 year from a covered facility, adult foster care facility, or mental health facility.

(c) The applicant can provide evidence acceptable to the relevant licensing or regulatory department that he or she has been a resident of this state for the immediately preceding 12-month period.

(11) As a condition of continued employment, each employee, independent contractor, or individual granted clinical privileges shall do each of the following:

(a) Agree in writing to report to the staffing agency or covered facility immediately upon being arraigned for 1 or more of the criminal offenses listed in subsection (1)(a) to (g), upon being convicted of 1 or more of the criminal offenses listed in subsection (1)(a) to (g), upon becoming the subject of an order or disposition described under subsection (1)(h), and upon being the subject of a substantiated finding of neglect, abuse, or misappropriation of property as described in subsection (1)(i). Reporting of an arraignment under this subdivision is not cause for termination or denial of employment.

(b) If a set of fingerprints is not already on file with the department of state police, provide the department of state police with a set of fingerprints.

(12) In addition to sanctions set forth in section 20165, a licensee, owner, administrator, or operator of a staffing agency or covered facility who knowingly and willfully fails to conduct the criminal history checks as required under this section is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than \$5,000.00, or both.

(13) In collaboration with the department of state police, the department of technology, management, and budget shall establish and maintain an automated fingerprint identification system database that would allow the department of state police to store and maintain all fingerprints submitted under this section and would provide for an automatic notification if and when a subsequent criminal arrest fingerprint card submitted into the system matches a set of fingerprints previously submitted under this section. Upon such notification, the department of state police shall immediately notify the department and the department shall immediately contact each respective staffing agency or covered facility with which that individual is associated. Information in the database established under this subsection is confidential, is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and shall not be disclosed to any person except for purposes of this act or for law enforcement purposes.

(14) The department shall maintain an electronic web-based system to assist staffing agencies and covered facilities required to check relevant registries and conduct criminal history checks of its employees, independent contractors, and individuals granted privileges and to provide for an automated notice to those staffing agencies and covered facilities for those individuals inputted in the system who, since the initial criminal history check, have been convicted of a disqualifying offense or have been the subject of a substantiated finding of abuse, neglect, or misappropriation of property. The department may charge a staffing agency a 1-time set-up fee of up to \$100.00 for access to the electronic web-based system under this section.

(15) As used in this section:

(a) "Adult foster care facility" means an adult foster care facility licensed under the adult foster care facility licensing act, 1979 PA 218, MCL 400.701 to 400.737.

(b) "Convicted" means either of the following:

(i) For a crime that is not a relevant crime, a final conviction, the payment of a fine, a plea of guilty or nolo contendere if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime.

(ii) For a relevant crime described under 42 USC 1320a-7(a), convicted means that term as defined in 42

USC 1320a-7.

(c) "Covered facility" means a health facility or agency that is a nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency.

(d) "Criminal history check conducted in compliance with this section" includes a criminal history check conducted under this section, under section 134a of the mental health code, 1974 PA 258, MCL 330.1134a, or under section 34b of the adult foster care facility licensing act, 1979 PA 218, MCL 400.734b.

(e) "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.

(f) "Home health agency" means a person certified by medicare whose business is to provide to individuals in their places of residence other than in a hospital, nursing home, or county medical care facility 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(g) "Independent contract" means a contract entered into by a covered facility with an individual who provides the contracted services independently or a contract entered into by a covered facility with a staffing agency that complies with the requirements of this section to provide the contracted services to the covered facility on behalf of the staffing agency.

(h) "Medicare" means benefits under the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395iii.

(i) "Mental health facility" means a psychiatric facility or intermediate care facility for people with mental retardation under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(j) "Staffing agency" means an entity that recruits candidates and provides temporary and permanent qualified staffing for covered facilities, including independent contractors.

(k) "Under the facility's control" means an individual employed by or under independent contract with a covered facility for whom the covered facility does both of the following:

(i) Determines whether the individual who has access to patients or residents may provide care, treatment, or other similar support service functions to patients or residents served by the covered facility.

(ii) Directs or oversees 1 or more of the following:

(A) The policy or procedures the individual must follow in performing his or her duties.

(B) The tasks performed by the individual.

(C) The individual's work schedule.

(D) The supervision or evaluation of the individual's work or job performance, including imposing discipline or granting performance awards.

(E) The compensation the individual receives for performing his or her duties.

(F) The conditions under which the individual performs his or her duties.

History: Add. 2006, Act 28, Eff. Apr. 1, 2006;—Am. 2008, Act 123, Imd. Eff. May 9, 2008;—Am. 2008, Act 443, Imd. Eff. Jan. 9, 2009;—Am. 2008, Act 444, Eff. Oct. 31, 2010;—Am. 2010, Act 291, Imd. Eff. Dec. 16, 2010.

Compiler's note: Enacting section 1 of Act 28 of 2006 provides:

"Enacting section 1. (1) Section 20173 of the public health code, 1978 PA 368, MCL 333.20173, is repealed effective April 1, 2006.

"(2) Section 20173a of the public health code, 1978 PA 368, MCL 333.20173a, as added by this amendatory act, takes effect April 1, 2006, since the department has secured the necessary federal approval to utilize federal funds to reimburse those facilities for the costs incurred for requesting a national criminal history check to be conducted by the federal bureau of investigation and the department has filed written notice of that approval with the secretary of state. The department shall issue a medicaid policy bulletin regarding the payment and reimbursement for the criminal history checks by April 1, 2006.

"(3) Section 20173b of the public health code, 1978 PA 368, MCL 333.20173b, as added by this amendatory act, takes effect the date this amendatory act is enacted."

333.20173b Individual disqualified or denied employment pursuant to MCL 333.20173a and 330.1134a; appeal; report to legislature; "business day" defined.

Sec. 20173b. (1) An individual who has been disqualified from or denied employment by a health facility or agency that is a nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency or by a psychiatric facility or intermediate care facility for people with mental retardation based on a criminal history check conducted pursuant to section 20173 or 20173a or pursuant to section 134a of the mental health code, 1974 PA 258, MCL 330.1134a, respectively, may appeal to the department if he or she believes that the criminal history report is inaccurate, and the appeal shall be conducted as a contested case hearing pursuant to the administrative procedures act of 1969. The individual shall file the appeal with the director of the department within 15 business days after receiving the written report of the criminal history check unless the conviction contained in the criminal history report is one that may be expunged or set aside. If an individual has been disqualified or denied employment based on a conviction that may be expunged or set aside, then he or she shall file the appeal on a form provided by the

department within 15 business days after a court order granting or denying his or her application to expunge or set aside that conviction is granted. If the order is granted and the conviction is expunged or set aside, then the individual shall not be disqualified or denied employment based solely on that conviction. The director shall review the appeal and issue a written decision within 30 business days after receiving the appeal. The decision of the director is final.

(2) One year after the effective date of this section and each year thereafter for the next 3 years, the department shall provide the legislature with a written report regarding the appeals process implemented under this section for employees subject to criminal history checks. The report shall include, but is not limited to, for the immediately preceding year the number of applications for appeal received, the number of inaccuracies found and appeals granted with regard to the criminal history checks conducted under section 20173a, the average number of days necessary to complete the appeals process for each appeal, and the number of appeals rejected without a hearing and a brief explanation of the denial.

(3) As used in this section, "business day" means a day other than a Saturday, Sunday, or any legal holiday.

History: Add. 2006, Act 28, Imd. Eff. Feb. 17, 2006.

Compiler's note: Enacting section 1 of Act 28 of 2006 provides:

"Enacting section 1. (1) Section 20173 of the public health code, 1978 PA 368, MCL 333.20173, is repealed effective April 1, 2006.

"(2) Section 20173a of the public health code, 1978 PA 368, MCL 333.20173a, as added by this amendatory act, takes effect April 1, 2006, since the department has secured the necessary federal approval to utilize federal funds to reimburse those facilities for the costs incurred for requesting a national criminal history check to be conducted by the federal bureau of investigation and the department has filed written notice of that approval with the secretary of state. The department shall issue a medicaid policy bulletin regarding the payment and reimbursement for the criminal history checks by April 1, 2006.

"(3) Section 20173b of the public health code, 1978 PA 368, MCL 333.20173b, as added by this amendatory act, takes effect the date this amendatory act is enacted."

333.20175 Maintaining record for each patient; confidentiality; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.

Sec. 20175. (1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a health facility or agency shall keep and retain each record for a minimum of 7 years from the date of service to which the record pertains. A health facility or agency shall maintain the records in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or his or her authorized representative as required by law. A health facility or agency may destroy a record that is less than 7 years old only if both of the following are satisfied:

(a) The health facility or agency sends a written notice to the patient at the last known address of that patient informing the patient that the record is about to be destroyed, offering the patient the opportunity to request a copy of that record, and requesting the patient's written authorization to destroy the record.

(b) The health facility or agency receives written authorization from the patient or his or her authorized representative agreeing to the destruction of the record. Except as otherwise provided under federal or state laws and regulations, records required to be maintained under this subsection may be destroyed or otherwise disposed of after being maintained for 7 years. If records maintained in accordance with this section are subsequently destroyed or otherwise disposed of, those records shall be shredded, incinerated, electronically deleted, or otherwise disposed of in a manner that ensures continued confidentiality of the patient's health care information and any other personal information relating to the patient. If records are destroyed or otherwise disposed of as provided under this subsection, the department may take action including, but not limited to, contracting for or making other arrangements to ensure that those records and any other confidential identifying information related to the patient are properly destroyed or disposed of to protect the confidentiality of patient's health care information and any other personal information relating to the patient. Before the department takes action in accordance with this subsection, the department, if able to identify the health facility or agency responsible for the improper destruction or disposal of the medical records at issue, shall send a written notice to that health facility or agency at the last known address on file with the department and provide the health facility or agency with an opportunity to properly destroy or dispose of those medical records as required under this subsection unless a delay in the proper destruction or disposal may compromise the patient's confidentiality. The department may assess the health facility or agency with the costs incurred by the department to enforce this subsection. In addition to the sanctions set forth in section

20165, a hospital that fails to comply with this subsection is subject to an administrative fine of \$10,000.00.

(2) A hospital shall take precautions to assure that the records required by subsection (1) are not wrongfully altered or destroyed. A hospital that fails to comply with this subsection is subject to an administrative fine of \$10,000.00.

(3) Unless otherwise provided by law, the licensing and certification records required by this article are public records.

(4) Departmental officers and employees shall respect the confidentiality of patient clinical records and shall not divulge or disclose the contents of records in a manner that identifies an individual except pursuant to court order or as otherwise authorized by law.

(5) A health facility or agency that employs, contracts with, or grants privileges to a health professional licensed or registered under article 15 shall report the following to the department not more than 30 days after it occurs:

(a) Disciplinary action taken by the health facility or agency against a health professional licensed or registered under article 15 based on the licensee's or registrant's professional competence, disciplinary action that results in a change of employment status, or disciplinary action based on conduct that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. As used in this subdivision, "adversely affects" means the reduction, restriction, suspension, revocation, denial, or failure to renew the clinical privileges of a licensee or registrant by a health facility or agency.

(b) Restriction or acceptance of the surrender of the clinical privileges of a licensee or registrant under either of the following circumstances:

(i) The licensee or registrant is under investigation by the health facility or agency.

(ii) There is an agreement in which the health facility or agency agrees not to conduct an investigation into the licensee's or registrant's alleged professional incompetence or improper professional conduct.

(c) A case in which a health professional resigns or terminates a contract or whose contract is not renewed instead of the health facility taking disciplinary action against the health professional.

(6) Upon request by another health facility or agency seeking a reference for purposes of changing or granting staff privileges, credentials, or employment, a health facility or agency that employs, contracts with, or grants privileges to health professionals licensed or registered under article 15 shall notify the requesting health facility or agency of any disciplinary or other action reportable under subsection (5) that it has taken against a health professional licensed or registered under article 15 and employed by, under contract to, or granted privileges by the health facility or agency.

(7) For the purpose of reporting disciplinary actions under this section, a health facility or agency shall include only the following in the information provided:

(a) The name of the licensee or registrant against whom disciplinary action has been taken.

(b) A description of the disciplinary action taken.

(c) The specific grounds for the disciplinary action taken.

(d) The date of the incident that is the basis for the disciplinary action.

(8) The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1986, Act 174, Imd. Eff. July 7, 1986;—Am. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 2000, Act 319, Imd. Eff. Oct. 24, 2000;—Am. 2006, Act 481, Imd. Eff. Dec. 22, 2006.

Compiler's note: Section 3 of Act 174 of 1986 provides: "This amendatory act shall only apply to contested cases filed on or after July 1, 1986."

Popular name: Act 368

333.20175a Agreement with another health facility to protect, maintain, and provide access to records; closure of health facility; noncompliance; fine; definitions.

Sec. 20175a. (1) If a health facility or agency is unable to comply with section 20175, the health facility or agency shall employ or contract, arrange, or enter into an agreement with another health facility or agency or a medical records company to protect, maintain, and provide access to those records required under section 20175(1).

(2) If a health facility or agency closes or otherwise ceases operation, the health facility or agency shall not abandon the records required to be maintained under section 20175(1) and shall send a written notice to the department that specifies who will have custody of the medical records and how a patient may request access to or copies of his or her medical records and shall do either of the following:

(a) Transfer the records required under section 20175(1) to any of the following:

(i) A successor health facility or agency.

(ii) If designated by the patient or his or her authorized representative, to the patient or a specific health facility or agency or a health care provider licensed or registered under article 15.

(iii) A health facility or agency or a medical records company with which the health facility or agency had contracted or entered into an agreement to protect, maintain, and provide access to those records required under section 20175(1).

(b) In accordance with section 20175(1), as long as the health facility or agency sends a written notice to the last known address of each patient for whom he or she has provided medical services and receives written authorization from the patient or his or her authorized representative, destroy the records required under section 20175(1). The notice shall provide the patient with 30 days to request a copy of his or her record or to designate where he or she would like his or her medical records transferred and shall request from the patient within 30 days written authorization for the destruction of his or her medical records. If the patient fails to request a copy or transfer of his or her medical records or to provide the health facility or agency with written authorization for the destruction, then the health facility or agency shall not destroy those records that are less than 7 years old but may destroy, in accordance with section 20175(1), those that are 7 years old or older.

(3) Nothing in this section shall be conducted to create or change the ownership rights to any medical records.

(4) A person that fails to comply with this section is subject to an administrative fine of not more than \$10,000.00 if the failure was the result of gross negligence or willful and wanton misconduct.

(5) As used in this section:

(a) "Medical record" or "record" means information, oral or recorded in any form or medium, that pertains to a patient's health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a licensee in the process of providing medical services.

(b) "Medical records company" means a person who contracts for or agrees to protect, maintain, and provide access to medical records for a health facility or agency in accordance with section 20175.

(c) "Patient" means an individual who receives or has received health care from a health care provider or health facility or agency. Patient includes a guardian, if appointed, and a parent, guardian, or person acting in loco parentis, if the individual is a minor, unless the minor lawfully obtained health care without the consent or notification of a parent, guardian, or other person acting in loco parentis, in which case the minor has the exclusive right to exercise the rights of a patient under this section with respect to his or her medical records relating to that care.

History: Add. 2006, Act 481, Imd. Eff. Dec. 22, 2006.

Popular name: Act 368

333.20176 Notice of violation; investigation of complaints; notice of proposed action; public record; appeal; reinvestigation.

Sec. 20176. (1) A person may notify the department of a violation of this article or of a rule promulgated under this article that the person believes exists. The department shall investigate each written complaint received and shall notify the complainant in writing of the results of a review or investigation of the complaint and any action proposed to be taken. Except as otherwise provided in sections 20180, 21743(1)(d), and 21799a, the name of the complainant and the charges contained in the complaint are a matter of public record.

(2) Except as otherwise provided in section 21799a, a complainant who is aggrieved by the decision of the department under this section may appeal to the director. After review of an appeal under this subsection, the director may order the department to reinvestigate the complaint.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1994, Act 52, Imd. Eff. Mar. 31, 1994.

Popular name: Act 368

333.20176a Health facility or agency; prohibited conduct; violation; fine.

Sec. 20176a. (1) A health facility or agency shall not discharge or discipline, threaten to discharge or discipline, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee or an individual acting on behalf of the employee does either or both of the following:

(a) In good faith reports or intends to report, verbally or in writing, the malpractice of a health professional or a violation of this article, article 7, or article 15 or a rule promulgated under this article, article 7, or article 15.

(b) Acts as an expert witness in a civil action involving medical malpractice or in an administrative action.

(2) In addition to the sanctions set forth in section 20165, a health facility or agency that violates subsection (1) is subject to an administrative fine of not more than \$10,000.00 for each violation.

History: Add. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 1994, Act 52, Imd. Eff. Mar. 31, 1994.

Popular name: Act 368

333.20177 Action to restrain, enjoin, or prevent establishment, maintenance, or operation of health facility or agency.

Sec. 20177. Notwithstanding the existence and pursuit of any other remedy, the director, without posting a bond, may request the prosecuting attorney or attorney general to bring an action in the name of the people of this state to restrain, enjoin, or prevent the establishment, maintenance, or operation of a health facility or agency in violation of this article or rules promulgated under this article.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20178 Nursing home, home for the aged, or county medical care facility; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.

Sec. 20178. (1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, a health facility or agency that is a nursing home, home for the aged, or county medical care facility that represents to the public that it provides inpatient care or services or residential care or services, or both, to persons with Alzheimer's disease or a related condition shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the health facility or agency to patients or residents with Alzheimer's disease or a related condition. A written description shall include, but not be limited to, all of the following:

(a) The overall philosophy and mission reflecting the needs of patients or residents with Alzheimer's disease or a related condition.

(b) The process and criteria for placement in or transfer or discharge from a program for patients or residents with Alzheimer's disease or a related condition.

(c) The process used for assessment and establishment of a plan of care and its implementation.

(d) Staff training and continuing education practices.

(e) The physical environment and design features appropriate to support the function of patients or residents with Alzheimer's disease or a related condition.

(f) The frequency and types of activities for patients or residents with Alzheimer's disease or a related condition.

(g) Identification of supplemental fees for services provided to patients or residents with Alzheimer's disease or a related condition.

(2) As used in this section, "represents to the public" means advertises or markets the facility as providing specialized Alzheimer's or dementia care services.

History: Add. 2000, Act 500, Imd. Eff. Jan. 11, 2001.

Popular name: Act 368

333.20179 Artificial insemination services on anonymous basis; use of frozen sperm; testing sperm donor for presence of HIV or antibody to HIV; violation; liability; definitions.

Sec. 20179. (1) A health facility or agency licensed under this article that provides artificial insemination services on an anonymous basis shall use only frozen sperm, and shall test each potential sperm donor for the presence in the donor of HIV or an antibody to HIV. The donated sperm shall be frozen, stored, and quarantined for not less than 6 months. Before frozen sperm is used for artificial insemination, and not less than 6 months after the date of the donation, the health facility or agency shall take a second blood sample from the donor and have that blood sample tested for HIV or an antibody to HIV. If at any time the test results are positive, the health facility or agency licensed under this article shall not use the sperm of the donor for artificial insemination purposes.

(2) A health facility or agency licensed under this article that violates this section shall be liable in a civil action for damages for the loss or damage resulting from the violation.

(3) As used in this section:

(a) "Anonymous basis" means that the recipient of the sperm does not know the identity of the donor, but the health facility or agency licensed under this article that provides the artificial insemination services or collects the sperm from the donor does know the identity of the donor.

(b) "HIV" means human immunodeficiency virus.

History: Add. 1988, Act 487, Eff. July 1, 1989.

Popular name: Act 368

333.20180 Health facility or agency; person making or assisting in originating, investigating, or preparing report or complaint; immunity and protection from civil or criminal liability; disclosure of identity; notice; “hospital” defined.

Sec. 20180. (1) A person employed by or under contract to a health facility or agency or any other person acting in good faith who makes a report or complaint including, but not limited to, a report or complaint of a violation of this article or a rule promulgated under this article; who assists in originating, investigating, or preparing a report or complaint; or who assists the department in carrying out its duties under this article is immune from civil or criminal liability that might otherwise be incurred and is protected under the whistleblowers' protection act, 1980 PA 469, MCL 15.361 to 15.369. A person described in this subsection who makes or assists in making a report or complaint, or who assists the department as described in this subsection, is presumed to have acted in good faith. The immunity from civil or criminal liability granted under this subsection extends only to acts done pursuant to this article.

(2) Unless a person described in subsection (1) otherwise agrees in writing, the department shall keep the person's identity confidential until disciplinary proceedings under this article are initiated against the subject of the report or complaint and the person making or assisting in originating, investigating, or preparing the report or complaint is required to testify in the disciplinary proceedings. If disclosure of the person's identity is considered by the department to be essential to the disciplinary proceedings and if the person is the complainant, the department shall give the person an opportunity to withdraw the complaint before disclosure.

(3) Subject to subsection (4), a person employed by or under contract to a hospital is immune from civil or criminal liability that might otherwise be incurred and shall not be discharged, threatened, or otherwise discriminated against by the hospital regarding that person's compensation or the terms, conditions, location, or privileges of that person's employment if that person reports to the department, verbally or in writing, an issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article. The protections afforded under this subsection do not limit, restrict, or diminish, in any way, the protections afforded under the whistleblowers' protection act, 1980 PA 469, MCL 15.361 to 15.369.

(4) Except as otherwise provided in subsection (5), a person employed by or under contract to a hospital is eligible for the immunity and protection provided under subsection (3) only if the person meets all of the following conditions before reporting to the department the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article:

(a) The person gave the hospital 60 days' written notice of the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article. A person who provides a hospital written notice as provided under this subdivision shall not be discharged, threatened, or otherwise discriminated against by the hospital regarding that person's compensation or the terms, conditions, location, or privileges of that person's employment. Within 60 days after receiving a written notice of an issue related to the hospital that is an unsafe practice or condition, the hospital shall provide a written response to the person who provided that written notice.

(b) The person had no reasonable expectation that the hospital had taken or would take timely action to address the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article.

(5) Subsection (4) does not apply if the person employed by or under contract to a hospital is required by law to report the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or a rule promulgated under this article before the expiration of the 60 days' notice required under subsection (4).

(6) A hospital shall post notices and use other appropriate means to keep a person employed by or under contract to the hospital informed of their protections and obligations under this section. The notices shall be in a form approved by the department. The notice shall be made available on the department's internet website and shall be posted in 1 or more conspicuous places where notices to persons employed by or under contract to a hospital are customarily posted.

(7) As used in this section, “hospital” means a hospital licensed under article 17.

History: Add. 1994, Act 52, Imd. Eff. Mar. 31, 1994;—Am. 2002, Act 731, Imd. Eff. Dec. 30, 2002.

Popular name: Act 368

333.20181 Abortion; admitting patient not required; refusal to perform, participate in, or allow; immunity.

Sec. 20181. A hospital, clinic, institution, teaching institution, or other health facility is not required to admit a patient for the purpose of performing an abortion. A hospital, clinic, institution, teaching institution,

or other health facility or a physician, member, or associate of the staff, or other person connected therewith, may refuse to perform, participate in, or allow to be performed on its premises an abortion. The refusal shall be with immunity from any civil or criminal liability or penalty.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20182 Abortion; objection; participation in medical procedures not required; immunity.

Sec. 20182. A physician, or other individual who is a member of or associated with a hospital, clinic, institution, teaching institution, or other health facility, or a nurse, medical student, student nurse, or other employee of a hospital, clinic, institution, teaching institution, or other health facility in which an abortion is performed, who states an objection to abortion on professional, ethical, moral, or religious grounds, is not required to participate in the medical procedures which will result in abortion. The refusal by the individual to participate does not create a liability for damages on account of the refusal or for any disciplinary or discriminatory action by the patient, hospital, clinic, institution, teaching institution, or other health facility against the individual.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20183 Abortion; refusal to give advice; refusal to participate in; immunity.

Sec. 20183. (1) A physician who informs a patient that he or she refuses to give advice concerning, or participate in, an abortion is not liable to the hospital, clinic, institution, teaching institution, health facility, or patient for the refusal.

(2) A civil action for negligence or malpractice or a disciplinary or discriminatory action may not be maintained against a person refusing to give advice as to, or participating in, an abortion based on the refusal.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20184 Rights of individuals, staff members, and employees previously participating in, or expressing willingness to participate in, termination of pregnancy.

Sec. 20184. A hospital, clinic, institution, teaching institution, or other health facility which refuses to allow abortions to be performed on its premises shall not deny staff privileges or employment to an individual for the sole reason that the individual previously participated in, or expressed a willingness to participate in, a termination of pregnancy. A hospital, clinic, institution, teaching institution, or other health facility shall not discriminate against its staff members or other employees for the sole reason that the staff members or employees have participated in, or have expressed a willingness to participate in, a termination of pregnancy.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20188 Repealed. 2004, Act 119, Eff. Nov. 27, 2005.

Compiler's note: The repealed section pertained to creation of commission on patient safety.

Popular name: Act 368

333.20191 Emergency patient; test for presence of infectious agent; positive test results; duties of health facility; notice; request for testing; confidentiality; rules; disclosure as misdemeanor; liability; definitions.

Sec. 20191. (1) If a police officer, fire fighter, individual licensed under section 20950 or 20952, or another individual assists an emergency patient who is subsequently transported to a health facility or transports an emergency patient to a health facility, and if the emergency patient, as part of the treatment rendered by the health facility or pursuant to a request made under subsection (2), is tested for the presence in the emergency patient of an infectious agent and the test results are positive, or is tested pursuant to a request made under subsection (2) for the presence in the emergency patient of the infectious agent of HIV or HBV and the test results are positive or negative, the health facility shall do all of the following:

(a) Subject to subsection (4) and subdivision (b), if the test results are positive for an infectious agent and the individual meets 1 of the following requirements, notify the individual on a form provided by the department that he or she may have been exposed to an infectious agent and, if the test results of a test conducted pursuant to subsection (2) are negative for the infectious agent of HIV or HBV, notify the individual of that fact:

(i) The individual is a police officer, fire fighter, or individual licensed under section 20950 or 20952.

(ii) The individual demonstrates in writing to the health facility that he or she was exposed to the blood, body fluids, or airborne agents of the emergency patient or participated in providing assistance to the emergency patient or transportation of the emergency patient to the health facility. An individual who makes a request under subsection (2) is exempt from the requirements of this subparagraph.

(b) Subject to subsection (4), if the test results indicate that the emergency patient is HIV infected, the health facility shall not reveal that the infectious agent is HIV unless the health facility has received a written request for notification from an individual described in subdivision (a)(i) or (ii). This subdivision does not apply if the test results indicate that the emergency patient is not HIV infected.

(c) Subject to subsection (4), on a form provided by the department, notify the individual described in subdivision (a), at a minimum, of the appropriate infection control precautions to be taken and the approximate date of the potential exposure. If the emergency patient is tested pursuant to a request made under subsection (2) for the presence in the emergency patient of the infectious agent of HIV or HBV, or both, and if the test results are positive or negative, the health facility also shall notify the individual described in subdivision (a) on the form provided by the department that he or she should be tested for HIV infection or HBV infection, or both, and counseled regarding both infectious agents.

(2) A police officer, fire fighter, individual licensed under section 20950 or 20952, or other individual who assists an emergency patient who is subsequently transported to a health facility or who transports an emergency patient to a health facility and who sustains a percutaneous, mucous membrane, or open wound exposure to the blood or body fluids of the emergency patient may request that the emergency patient be tested for HIV infection or HBV infection, or both, pursuant to this subsection. The police officer, fire fighter, individual licensed under section 20950 or 20952, or other individual shall make a request to a health facility under this subsection in writing on a form provided by the department and before the emergency patient is discharged from the health facility. The request form shall be dated and shall contain at a minimum the name and address of the individual making the request and a description of the individual's exposure to the emergency patient's blood or other body fluids. The request form shall contain a space for the information required under subsection (3) and a statement that the requester is subject to the confidentiality requirements of subsection (5) and section 5131. The request form shall not contain information that would identify the emergency patient by name. A health facility that receives a request under this subsection shall accept as fact the requester's description of his or her exposure to the emergency patient's blood or other body fluids, unless the health facility has reasonable cause to believe otherwise. The health facility shall make a determination as to whether or not the exposure described in the request was a percutaneous, mucous membrane, or open wound exposure pursuant to R 325.70001 to R 325.70018 of the Michigan administrative code. If the health facility determines that the exposure described in the request was a percutaneous, mucous membrane, or open wound exposure, the health facility shall test the emergency patient for HIV infection or HBV infection, or both, as indicated in the request. A health facility that performs a test under this subsection may charge the individual requesting the test for the reasonable and customary charges of the test. The individual requesting the test is responsible for the payment of the charges if the charges are not payable by the individual's employer, pursuant to an agreement between the individual and the employer, or by the individual's health care payment or benefits plan. A health facility is not required to provide HIV counseling pursuant to section 5133(1) to an individual who requests that an emergency patient be tested for HIV under this subsection, unless the health facility tests the requesting individual for HIV.

(3) A health facility shall comply with this subsection if the health facility receives a request under subsection (2) and determines either that there is reasonable cause to disbelieve the requester's description of his or her exposure or that the exposure was not a percutaneous, mucous membrane, or open wound exposure and as a result of the determination the health facility is not required to test the emergency patient for HIV infection or HBV infection, or both. A health facility shall also comply with this subsection if the health facility receives a request under subsection (2) and determines that the exposure was a percutaneous, mucous membrane, or open wound exposure, but is unable to test the emergency patient for HIV infection or HBV infection, or both. The health facility shall state in writing on the request form the reasons for disbelieving the requester's description of his or her exposure, the health facility's exposure determination, or the inability to test the emergency patient, as applicable. The health facility shall transmit a copy of the completed request form to the requesting individual within 2 days after the date the determination is made that the health facility has reasonable cause to disbelieve the requester's description of his or her exposure or that the exposure was not a percutaneous, mucous membrane, or open wound exposure or within 2 days after the date the health facility determines that it is unable to test the emergency patient for HIV infection or HBV infection, or both.

(4) The notification required under subsection (1) shall occur within 2 days after the test results are obtained by the health facility or after receipt of a written request under subsection (1)(b). The notification shall be transmitted to the potentially exposed individual or, upon request of the individual, to the individual's

primary care physician or other health professional designated by the individual, as follows:

(a) If the potentially exposed individual provides his or her name and address or the name and address of the individual's primary care physician or other health professional designated by the individual to the health facility or if the health facility has a procedure that allows the health facility in the ordinary course of its business to determine the individual's name and address or the name and address of the individual's primary care physician or other health professional designated by the individual, the health facility shall notify the individual or the individual's primary care physician or other health professional designated by the individual directly at that address.

(b) If the potentially exposed individual is a police officer, fire fighter, or individual licensed under section 20950 or 20952, and if the health facility does not have the name of the potentially exposed individual or the individual's primary care physician or other health professional designated by the individual, the health facility shall notify the appropriate police department, fire department, or life support agency that employs or dispatches the individual. If the health facility is unable to determine the employer of an individual described in this subdivision, the health facility shall notify the medical control authority or chief elected official of the governmental unit that has jurisdiction over the transporting vehicle.

(c) A medical control authority or chief elected official described in subdivision (b) shall notify the potentially exposed individual or the individual's primary care physician or other health professional designated by the individual or, if unable to notify the potentially exposed individual or the individual's primary care physician or other health professional designated by the individual, shall document in writing the notification efforts and reasons for being unable to make the notification.

(5) The notice required under subsection (1) shall not contain information that would identify the emergency patient who tested positive for an infectious agent or who tested positive or negative for the presence in the emergency patient of the infectious agent of HIV or HBV. The information contained in the notice is confidential and is subject to this section, the rules promulgated under section 5111, and section 5131. A person who receives confidential information under this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

(6) The department shall promulgate rules to administer this section. The department shall develop and distribute the forms required under subsections (1)(a) and (c) and (2).

(7) Except as otherwise provided in this subsection, a person who discloses information regarding an infectious agent in violation of subsection (5) is guilty of a misdemeanor. This subsection does not apply to the disclosure of information regarding a serious communicable disease or infection, if the disclosure is subject to rules promulgated under section 5111 or to section 5131.

(8) A person or governmental entity that makes a good faith effort to comply with subsection (1), (2), (3), or (4) is immune from any civil liability or criminal penalty based on compliance or the failure to comply.

(9) As used in this section:

(a) "Emergency patient" means an individual who is transported to an organized emergency department located in and operated by a hospital licensed under this article or a facility other than a hospital that is routinely available for the general care of medical patients.

(b) "HBV" means hepatitis B virus.

(c) "HBV infected" or "HBV infection" means the status of an individual who is tested as HBsAg-positive.

(d) "Health facility" means a health facility or agency as defined in section 20106.

(e) "HIV" means human immunodeficiency virus.

(f) "HIV infected" means that term as defined in section 5101.

(g) "Infectious agent" means that term as defined in R 325.9031 of the Michigan administrative code.

(h) "Life support agency" means that term as defined in section 20906.

(i) "Serious communicable disease or infection" means that term as defined in section 5101.

History: Add. 1988, Act 490, Eff. Mar. 30, 1989;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1994, Act 419, Eff. Mar 30, 1995;—Am. 2010, Act 119, Imd. Eff. July 13, 2010.

Popular name: Act 368

333.20192 Do-not-resuscitate order; execution not required.

Sec. 20192. A health facility or agency shall not require the execution of a do-not-resuscitate order under the Michigan do-not-resuscitate procedure act as a condition for admission or receipt of services.

History: Add. 1996, Act 192, Eff. Aug. 1, 1996.

Popular name: Act 368

333.20193 Compliance.

Sec. 20193. A health facility or agency shall comply with part 138.

History: Add. 1990, Act 21, Eff. June 4, 1990.

Popular name: Act 368

333.20194 Pamphlets; display; distribution; model standardized complaint form; availability.

Sec. 20194. (1) Subject to subsections (2), (3), and (4), a health facility or agency, except a health facility or agency licensed under part 209, and including a health facility that is not licensed under this article but holds itself out as providing medical services, shall conspicuously display in the patient waiting areas or other common areas of the health facility or agency copies of a pamphlet developed by the department of consumer and industry services outlining the procedure for filing a complaint against a health facility or agency with the department and the procedure for filing a complaint against an individual who is licensed or registered under article 15 and employed by, under contract to, or granted privileges by the health facility or agency. The pamphlet shall be developed and distributed by the department of consumer and industry services after consultation with appropriate professional associations.

(2) The department of consumer and industry services shall develop the pamphlets required under subsection (1) in languages that are appropriate to the ethnic composition of the patient population where the pamphlet will be displayed. The department shall use large, easily readable type and nontechnical, easily understood language in the pamphlet. The department shall periodically distribute copies of the pamphlet to each health facility or agency and to each unlicensed health facility described in subsection (1).

(3) The department of consumer and industry services shall include a model standardized complaint form in the pamphlet described in subsection (1). The department may develop a separate model standardized complaint form that is specific to a particular health facility or agency or category of health facilities and agencies. The department shall develop a model standardized complaint form that is specific to nursing homes. The department shall include on the model standardized complaint form, at a minimum, simple instructions on how to file a complaint, including with the nursing home as required under section 21723, the department, the state long-term care ombudsman, the Michigan protection and advocacy service, inc., and the health care fraud unit of the department of attorney general. The department shall distribute copies of the model standardized complaint form simultaneously with copies of the pamphlet as required under subsection (2). The nursing home shall conspicuously display and make available multiple copies of the pamphlet and model standardized complaint form with the complaint information required to be posted under section 21723 in the patient waiting areas or other common areas of the nursing home that are easily accessible to nursing home patients and their visitors, as described in subsection (1), and shall provide a copy of the pamphlet and complaint form to each nursing home resident or the resident's surrogate decision maker upon admission to the nursing home. The department shall include on the model standardized complaint form a telephone number for the receipt of oral complaints.

(4) The department may continue to distribute the complaint pamphlets within its possession on the effective date of the amendatory act that added this subsection until the department's stock is exhausted or until October 1, 2003, whichever is sooner. Beginning October 1, 2003, the department shall only distribute the complaint pamphlets and model standardized complaint forms that are in compliance with subsections (2) and (3).

(5) The department shall make the complaint pamphlet and the model standardized complaint form available to the public on the department's internet website. The department shall take affirmative action toward the development and implementation of an electronic filing system that would allow an individual to file a complaint through the website.

History: Add. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 2003, Act 3, Imd. Eff. Apr. 22, 2003.

Popular name: Act 368

333.20197 Human cloning in facility owned or operated by health facility or agency.

Sec. 20197. (1) A health facility or agency shall not allow a licensee or registrant under article 15 or any other individual to engage in or attempt to engage in human cloning in a facility owned or operated by the health facility or agency.

(2) Subsection (1) does not prohibit a health facility or agency from allowing a licensee or registrant under article 15 or any other individual from engaging in scientific research or cell-based therapies not specifically prohibited by that subsection.

(3) A health facility or agency that violates subsection (1) is subject to the administrative penalties prescribed in section 20165(4).

(4) This section does not give a person a private right of action.

(5) As used in this section, "human cloning" means that term as defined in section 16274.

History: Add. 1998, Act 108, Eff. Mar. 23, 1999.

Popular name: Act 368

333.20198 Health facility, agency inpatient facility, or residential facility; prohibited conduct; violation as misdemeanor; penalty; nonapplicability of subsections (1) and (2).

Sec. 20198. (1) Subject to subsection (3), an individual shall not enter upon the premises of a health facility or agency that is an inpatient facility, an outpatient facility, or a residential facility for the purpose of engaging in an activity that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested and that actually causes a health facility or agency employee, patient, resident, or visitor to feel terrorized, frightened, intimidated, threatened, harassed, or molested. This subsection does not prohibit constitutionally protected activity or conduct that serves a legitimate purpose.

(2) An individual who violates subsection (1) is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year or a fine of not less than \$1,000.00 or more than \$10,000.00, or both.

(3) Subsections (1) and (2) do not apply to a nursing home covered under sections 21763(5) and 21799c(1)(c).

History: Add. 1998, Act 270, Eff. Mar. 23, 1999.

Popular name: Act 368

333.20199 Violations; penalties.

Sec. 20199. (1) Except as provided in subsection (2) or section 20142, a person who violates this article or a rule promulgated or an order issued under this article is guilty of a misdemeanor, punishable by fine of not more than \$1,000.00 for each day the violation continues or, in case of a violation of sections 20551 to 20554, a fine of not more than \$1,000.00 for each occurrence.

(2) A person who violates sections 20181 to 20184 is guilty of a misdemeanor, punishable by imprisonment for not more than 6 months, or a fine of not more than \$2,000.00, or both.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.20201 Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.

Sec. 20201. (1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.

(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:

(a) A patient or resident shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.

(b) An individual who is or has been a patient or resident is entitled to inspect, or receive for a reasonable fee, a copy of his or her medical record upon request in accordance with the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271. Except as otherwise permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, a third party shall not be given a copy of the patient's or resident's medical record without prior authorization of the patient or resident.

(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.

(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand,

unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(f) A patient or resident is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. If a refusal of treatment prevents a health facility or agency or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice.

(g) A patient or resident is entitled to exercise his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal. A patient or resident is entitled to information about the health facility's or agency's policies and procedures for initiation, review, and resolution of patient or resident complaints.

(h) A patient or resident is entitled to information concerning an experimental procedure proposed as a part of his or her care and has the right to refuse to participate in the experimental procedure without jeopardizing his or her continuing care.

(i) A patient or resident is entitled to receive and examine an explanation of his or her bill regardless of the source of payment and to receive, upon request, information relating to financial assistance available through the health facility or agency.

(j) A patient or resident is entitled to know who is responsible for and who is providing his or her direct care, is entitled to receive information concerning his or her continuing health needs and alternatives for meeting those needs, and to be involved in his or her discharge planning, if appropriate.

(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.

(m) A patient or resident is entitled to be free from performing services for the health facility or agency that are not included for therapeutic purposes in the plan of care.

(n) A patient or resident is entitled to information about the health facility or agency rules and regulations affecting patient or resident care and conduct.

(o) A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.

(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217:

(a) The policy shall be provided to each nursing home patient or home for the aged resident upon admission, and the staff of the facility shall be trained and involved in the implementation of the policy.

(b) Each nursing home patient may associate and communicate privately with persons of his or her choice. Reasonable, regular visiting hours, which shall be not less than 8 hours per day, and which shall take into consideration the special circumstances of each visitor, shall be established for patients to receive visitors. A patient may be visited by the patient's attorney or by representatives of the departments named in section 20156, during other than established visiting hours. Reasonable privacy shall be afforded for visitation of a patient who shares a room with another patient. Each patient shall have reasonable access to a telephone. A married nursing home patient or home for the aged resident is entitled to meet privately with his or her spouse

in a room that assures privacy. If both spouses are residents in the same facility, they are entitled to share a room unless medically contraindicated and documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(c) A nursing home patient or home for the aged resident is entitled to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or residents, or unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. Each nursing home patient or home for the aged resident shall be provided with reasonable space. At the request of a patient, a nursing home shall provide for the safekeeping of personal effects, funds, and other property of a patient in accordance with section 21767, except that a nursing home is not required to provide for the safekeeping of a property that would impose an unreasonable burden on the nursing home.

(d) A nursing home patient or home for the aged resident is entitled to the opportunity to participate in the planning of his or her medical treatment. The attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services shall fully inform the nursing home patient of the patient's medical condition unless medically contraindicated as documented in the medical record by a physician or a physician's assistant to whom the physician has delegated the performance of medical care services. Each nursing home patient shall be afforded the opportunity to discharge himself or herself from the nursing home.

(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.

(f) A nursing home patient or home for the aged resident is entitled to be fully informed before or at the time of admission and during stay of services available in the facility, and of the related charges including any charges for services not covered under title XVIII, or not covered by the facility's basic per diem rate. The statement of services provided by the facility shall be in writing and shall include those required to be offered on an as-needed basis.

(g) A nursing home patient or home for the aged resident is entitled to manage his or her own financial affairs, or to have at least a quarterly accounting of personal financial transactions undertaken in his or her behalf by the facility during a period of time the patient or resident has delegated those responsibilities to the facility. In addition, a patient or resident is entitled to receive each month from the facility an itemized statement setting forth the services paid for by or on behalf of the patient and the services rendered by the facility. The admission of a patient to a nursing home does not confer on the nursing home or its owner, administrator, employees, or representatives the authority to manage, use, or dispose of a patient's property.

(h) A nursing home patient or a person authorized by the patient in writing may inspect and copy the patient's personal and medical records. The records shall be made available for inspection and copying by the nursing home within a reasonable time, not exceeding 1 week, after the receipt of a written request.

(i) If a nursing home patient desires treatment by a licensed member of the healing arts, the treatment shall be made available unless it is medically contraindicated, and the medical contraindication is justified in the patient's medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(j) A nursing home patient has the right to have his or her parents, if a minor, or his or her spouse, next of kin, or patient's representative, if an adult, stay at the facility 24 hours a day if the patient is considered terminally ill by the physician responsible for the patient's care or a physician's assistant to whom the physician has delegated the performance of medical care services.

(k) Each nursing home patient shall be provided with meals that meet the recommended dietary allowances for that patient's age and sex and that may be modified according to special dietary needs or ability to chew.

(l) Each nursing home patient has the right to receive representatives of approved organizations as provided in section 21763.

(4) A nursing home, its owner, administrator, employee, or representative shall not discharge, harass, or retaliate or discriminate against a patient because the patient has exercised a right protected under this section.

(5) In the case of a nursing home patient, the rights enumerated in subsection (2)(c), (g), and (k) and subsection (3)(d), (g), and (h) may be exercised by the patient's representative.

(6) A nursing home patient or home for the aged resident is entitled to be fully informed, as evidenced by the patient's or resident's written acknowledgment, before or at the time of admission and during stay, of the policy required by this section. The policy shall provide that if a patient or resident is adjudicated incompetent and not restored to legal capacity, the rights and responsibilities set forth in this section shall be exercised by a

person designated by the patient or resident. The health facility or agency shall provide proper forms for the patient or resident to provide for the designation of this person at the time of admission.

(7) This section does not prohibit a health facility or agency from establishing and recognizing additional patients' rights.

(8) As used in this section:

(a) "Patient's representative" means that term as defined in section 21703.

(b) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(c) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-5.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1982, Act 354, Imd. Eff. Dec. 21, 1982;—Am. 1998, Act 88, Imd. Eff. May 13, 1998;—Am. 2001, Act 240, Imd. Eff. Jan. 8, 2002;—Am. 2006, Act 38, Imd. Eff. Mar. 2, 2006;—Am. 2011, Act 210, Imd. Eff. Nov. 8, 2011.

Popular name: Act 368

Popular name: Patient Rights

333.20202 Responsibilities of patient or resident.

Sec. 20202. (1) A patient or resident is responsible for following the health facility rules and regulations affecting patient or resident care and conduct.

(2) A patient or resident is responsible for providing a complete and accurate medical history.

(3) A patient or resident is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do.

(4) A patient or resident is responsible for following the recommendations and advice prescribed in a course of treatment by the physician.

(5) A patient or resident is responsible for providing information about unexpected complications that arise in an expected course of treatment.

(6) A patient or resident is responsible for being considerate of the rights of other patients or residents and health facility personnel and property.

(7) A patient or resident is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20203 Guidelines; immunity; other remedies at law neither expanded nor diminished.

Sec. 20203. (1) The rights and responsibilities prescribed in sections 20201 and 20202 are guidelines for health facilities, facility staff, facility employees, patients, and residents. An individual shall not be civilly or criminally liable for failure to comply with those sections.

(2) Sections 20201 and 20202 shall not be construed to expand or diminish other remedies at law available to a patient or resident under this code or the statutory and common law of this state.

(3) The department shall develop guidelines to assist health facilities and agencies in the implementation of sections 20201 and 20202.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20211 Summary of activities; availability of list and current inspection reports.

Sec. 20211. (1) Every 6 months the department shall issue a summary of its activities in relation to licensing and regulation and shall cause the information to be made available to the news media and all persons who make a written request to receive copies of the information.

(2) The list and current inspection reports shall be available for inspection and copying.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

PART 203

AMBULANCE OPERATIONS AND ADVANCED MOBILE EMERGENCY CARE SERVICES

333.20301-333.20382 Repealed. 1981, Act 79, Imd. Eff. June 30, 1981.

Popular name: Act 368

PART 205

CLINICAL AND OTHER LABORATORIES

333.20501 Definitions; principles of construction.

Sec. 20501. (1) As used in this part:

(a) "Laboratory director" means the individual responsible for administration of the technical and scientific operation of a clinical laboratory, including the supervision of procedures and reporting of findings.

(b) "Owner" means a person who owns and controls a clinical laboratory.

(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.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.20507 Laboratories to which MCL 333.20501 to 333.20525 inapplicable.

Sec. 20507. Sections 20501 to 20525 do not apply to any of the following:

(a) A laboratory where examinations are always performed personally by the individual desiring the information.

(b) A laboratory operated by an individual licensed to practice medicine, osteopathic medicine and surgery, dentistry, or podiatry who performs clinical laboratory tests or procedures personally or through his or her employees only as an adjunct to the treatment of the licensee's patients.

(c) A laboratory operated in the manner described in subdivision (b) by a group of not more than 5 individuals licensed to practice medicine, osteopathic medicine and surgery, dentistry, or podiatry.

(d) A laboratory operated by a college, university, or school approved by the department of education that is conducted for the training of its students, if the result of an examination performed in the clinical laboratory is not used in the diagnosis and treatment of disease.

(e) A laboratory operated by the federal government.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20511 Clinical laboratory; license required; authorizing specific categories of procedures; contents of license; display of license and laboratory director's certificate of qualification; duration of license validity; biennial visits; manner of conducting licensing and inspection activities.

Sec. 20511. (1) A clinical laboratory shall be licensed under this article.

(2) A license shall authorize specific categories of procedures which the clinical laboratory may perform.

(3) A license shall contain on its face the name of the owner of the clinical laboratory, the name of the laboratory director, the categories of laboratory procedures authorized to be performed in the clinical laboratory, and the location at which the procedures may be performed.

(4) The license and laboratory director's certificate of qualification, if required, shall be displayed at all times in a prominent place in the clinical laboratory.

(5) A clinical laboratory license is valid for not more than 2 years after the date of issuance. Except where the department has entered into agreements as provided in section 20155(5), the department shall make at least biennial visits to clinical laboratories for the purposes of survey, evaluation, and consultation. The department shall conduct licensing and inspection activities in such a manner as to maximize discovery of changes in laboratory personnel and operations and to take advantage of inspections by voluntary accrediting organizations.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1982, Act 474, Eff. Mar. 30, 1983.

Popular name: Act 368

333.20515 Requirements for license.

Sec. 20515. A license shall not be issued unless:

(a) The laboratory director has training, education, or experience related to the safe and competent administration of a clinical laboratory as prescribed by departmental rules.

(b) The department finds that the clinical laboratory is competently staffed, properly located and constructed, and properly equipped to perform the clinical laboratory procedures for which the license is

sought.

(c) The owner agrees and the department determines that the clinical laboratory will be operated in the manner required by this article.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20521 Responsibility for operation of clinical laboratory; record of specimens and procedures; analysis of test samples; reports; proficiency evaluation programs.

Sec. 20521. (1) The owner, laboratory director, and governing body of a clinical laboratory are responsible for the operation of the clinical laboratory.

(2) The laboratory director is responsible for the making and keeping of an accurate record for each specimen examined and procedure followed.

(3) A clinical laboratory shall analyze test samples submitted by the department and report to the department on the results of the analyses, except that proficiency evaluation programs of recognized professional organizations may be acceptable to the department in lieu thereof. The analyses and reports may be considered by the department in taking action under section 20165 or 20525.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20525 Denial, limitation, suspension, or revocation of license; grounds.

Sec. 20525. In addition to the grounds for disciplinary action set forth in section 20165 the department may deny, limit, suspend, or revoke a license upon a finding that the owner, laboratory director, or an employee of a clinical laboratory has done any of the following:

(a) Demonstrated incompetence or consistently erred in the performance of the clinical laboratory examinations or procedures.

(b) Performed, or represented himself or herself as entitled to perform, a clinical laboratory procedure or category of procedures not authorized in the certificate of licensure.

(c) Solicited referral of specimens to the clinical laboratory by false advertising or by offering or implying, directly or indirectly, discounts, rebates, or other benefits or considerations to persons referring patients or work to the clinical laboratory.

(d) Reported on clinical laboratory work or referred samples required to be tested under section 20521 actually performed in another laboratory without stating that the work was performed there.

(e) Billed patients or third party payors for laboratory work not actually performed or not requested by the patient's physician.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20531 Lead analysis; clinical laboratory reporting requirements.

Sec. 20531. Not later than 90 days after the effective date of this section, the department shall mail a notice to each clinical laboratory doing business in this state explaining the reporting requirements of this section. Beginning October 1, 2005, a clinical laboratory that analyzes a blood sample for lead shall report the results of the blood lead analysis to the department electronically in a format as prescribed by the department. The clinical laboratory shall submit the report to the department as required under this section within 5 days after the analysis is completed.

History: Add. 2004, Act 54, Imd. Eff. Apr. 12, 2004.

Popular name: Act 368

333.20551 Registration of laboratory or other place handling, cultivating, selling, giving away, or shipping pathogenic microorganisms, or doing recombinant deoxyribonucleic acid research; application for and duration of registration number; clinical laboratory considered registered; "handling," "cultivating," "shipping" defined.

Sec. 20551. (1) A laboratory or other place where live bacteria, fungi, mycoplasma, parasites, viruses, or other microorganisms of a pathogenic nature are handled, cultivated, sold, given away, or shipped from or to or where recombinant deoxyribonucleic acid research is done shall be registered with the department, and a registration number shall be issued to each place registered. An application for a registration number shall be made by the person in charge of the laboratory or other place where the pathogens are handled or where recombinant deoxyribonucleic acid research is done. The registration number is valid for 1 year and may be renewed upon application to the department.

(2) A clinical laboratory licensed in microbiology under sections 20501 to 20525 is registered for purposes of this section and section 20552, and its license number shall be used as its registration number.

(3) As used in sections 20551 and 20552, “handled”, “cultivated”, or “shipped” does not include the collection of specimens, the initial inoculation of specimens into transport media or culture media, or the shipment to registered laboratories, but does include any additional work performed on cultivated pathogenic microorganisms or any recombinant deoxyribonucleic acid research is done.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20552 Registration of laboratory, department, or school handling pathogens or doing recombinant deoxyribonucleic acid research; application for and duration of registration number.

Sec. 20552. The department shall register a laboratory or a department of a college, university, or school which is responsible for the handling, cultivating, selling, giving away, or shipping of the microorganisms described in section 20551(1) or is engaged in recombinant deoxyribonucleic acid research. The person in charge of the laboratory or department where the pathogens are handled or where recombinant deoxyribonucleic acid research is done shall apply for a registration number. The registration is valid for 1 year and may be renewed upon application.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20554 Sale, gift, or other distribution of live pathogenic microorganisms and cultures or recombinant deoxyribonucleic acid materials; contents of label on container; record.

Sec. 20554. Live pathogenic bacteria, fungi, mycoplasma, parasites, viruses, or other microorganisms or cultures of the microorganisms when sold, given away, or shipped by a laboratory or other person, shall bear a label on the container showing the registration number of the laboratory or other person sending the specimens and the name and address of the person to whom sent. A laboratory or person shall not sell or convey a live pathogenic microorganism or recombinant deoxyribonucleic acid materials to any other laboratory or person in this state without permission of the department unless each is registered under section 20551 or 20552. The laboratory or person shall keep a record of each sale, gift, or other distribution of live pathogenic microorganisms and cultures or recombinant deoxyribonucleic acid materials containing the name and laboratory address of the recipient or purchaser. The record shall be at all times open to examination and copying by a representative of the department.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

PART 206

COUNTY MEDICAL CARE FACILITIES

333.20601-333.20621 Repealed. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

PART 207

EMERGENCY MEDICAL SERVICES

333.20701-333.20773 Expired. 1981, Act 79, Eff. Sept. 30, 1989;—Repealed, 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

PART 208

FREESTANDING SURGICAL OUTPATIENT FACILITIES

333.20801 General definitions and principles of construction.

Sec. 20801. 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.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of

commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.20811 License required; use of term “freestanding surgical outpatient facility.”

Sec. 20811. (1) A freestanding surgical outpatient facility shall be licensed under this article.

(2) “Freestanding surgical outpatient facility” or a 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.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20813 Owner, operator, and governing body of freestanding surgical outpatient facility; responsibilities and duties.

Sec. 20813. The owner, operator, and governing body of a freestanding surgical outpatient facility licensed under this article:

(a) Are responsible for all phases of the operation of the facility, selection of medical staff, and quality of care rendered in the facility.

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

(c) Shall assure that physicians admitted to practice in the facility are granted professional privileges consistent with the capability of the facility and with the physicians' individual training, experience, and other qualifications.

(d) Shall assure that physicians admitted to practice in the facility are organized into a medical staff to enable an effective review of the professional practices of the facility for the purpose of reducing morbidity and mortality and improving the care provided in the facility for patients.

(e) Shall assure that the facility does not pay a fee to compensate or reimburse a medical referral agency or other person that refers or recommends an individual to a facility for any form of medical or surgical care or treatment.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.20821 Freestanding surgical outpatient facility; requirements.

Sec. 20821. A freestanding surgical outpatient facility shall:

(a) Be organized, administered, staffed, and equipped to provide on a regular and scheduled basis major and minor surgical procedures outside a hospital which in a physician's judgment may be safely performed on a basis other than on an inpatient basis.

(b) Have the physician, professional nursing, technical, and supportive personnel; the technical, diagnostic, and treatment services; and the equipment necessary to assure the safe performance of surgery and related care undertaken in the facility.

(c) Have a written agreement with a nearby licensed hospital to provide for the emergency admission of postsurgical patients who for unpredictable reasons may require hospital admission and care.

(d) Assure that a clinical record is established for each patient including a history, physical examination, justification for treatment planned and rendered, tests and examinations performed, observations made, and treatment provided.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

PART 209

EMERGENCY MEDICAL SERVICES

333.20901 Meanings of words and phrases; general definitions and principles of construction.

Sec. 20901. (1) For purposes of this part, the words and phrases defined in sections 20902 to 20908 have the meanings ascribed to them in those sections.

(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.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

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Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.20902 Definitions; A to D.

Sec. 20902. (1) "Advanced life support" means patient care that may include any care a paramedic is qualified to provide by paramedic education that meets the educational requirements established by the department under section 20912 or is authorized to provide by the protocols established by the local medical control authority under section 20919 for a paramedic.

(2) "Aircraft transport operation" means a person licensed under this part to provide patient transport, for profit or otherwise, between health facilities using an aircraft transport vehicle.

(3) "Aircraft transport vehicle" means an aircraft that is primarily used or designated as available to provide patient transportation between health facilities and that is capable of providing patient care according to orders issued by the patient's physician.

(4) "Ambulance" means a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

(5) "Ambulance operation" means a person licensed under this part to provide emergency medical services and patient transport, for profit or otherwise.

(6) "Basic life support" means patient care that may include any care an emergency medical technician is qualified to provide by emergency medical technician education that meets the educational requirements established by the department under section 20912 or is authorized to provide by the protocols established by the local medical control authority under section 20919 for an emergency medical technician.

(7) "Clinical preceptor" means an individual who is designated by or under contract with an education program sponsor for purposes of overseeing the students of an education program sponsor during the participation of the students in clinical training.

(8) "Disaster" means an occurrence of imminent threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or man-made cause, including but not limited to, fire, flood, snow, ice, windstorm, wave action, oil spill, water contamination requiring emergency action to avert danger or damage, utility failure, hazardous peacetime radiological incident, major transportation accident, hazardous materials accident, epidemic, air contamination, drought, infestation, or explosion. Disaster does not include a riot or other civil disorder unless it directly results from and is an aggravating element of the disaster.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20904 Definitions; E.

Sec. 20904. (1) "Education program sponsor" means a person, other than an individual, that meets the standards of the department to conduct training at the following levels:

- (a) Medical first responder.
- (b) Emergency medical technician.
- (c) Emergency medical technician specialist.
- (d) Paramedic.
- (e) Emergency medical services instructor-coordinator.

(2) "Emergency" means a condition or situation in which an individual declares a need for immediate medical attention for any individual, or where that need is declared by emergency medical services personnel or a public safety official.

(3) "Emergency medical services instructor-coordinator" means an individual licensed under this part to conduct and instruct emergency medical services education programs.

(4) "Emergency medical services" means the emergency medical services personnel, ambulances, nontransport prehospital life support vehicles, aircraft transport vehicles, medical first response vehicles, and equipment required for transport or treatment of an individual requiring medical first response life support, basic life support, limited advanced life support, or advanced life support.

(5) "Emergency medical services personnel" means a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or emergency medical services instructor-coordinator.

(6) "Emergency medical services system" means a comprehensive and integrated arrangement of the

personnel, facilities, equipment, services, communications, medical control, and organizations necessary to provide emergency medical services and trauma care within a particular geographic region.

(7) "Emergency medical technician" means an individual who is licensed by the department to provide basic life support.

(8) "Emergency medical technician specialist" means an individual who is licensed by the department to provide limited advanced life support.

(9) "Emergency patient" means an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in 1 or all of the following:

(a) Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.

(b) Serious impairment of bodily function.

(c) Serious dysfunction of a body organ or part.

(10) "Examination" means a written and practical evaluation approved or developed by the national registry of emergency medical technicians or other organization with equivalent national recognition and expertise in emergency medical services personnel testing and approved by the department.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20906 Definitions; L, M.

Sec. 20906. (1) "Life support agency" means an ambulance operation, nontransport prehospital life support operation, aircraft transport operation, or medical first response service.

(2) "Life support vehicle" means an ambulance, nontransport prehospital life support vehicle, aircraft transport vehicle, or medical first response vehicle.

(3) "Limited advanced life support" means patient care that may include any care an emergency medical technician specialist is qualified to provide by emergency medical technician specialist education that meets the educational requirements established by the department under section 20912 or is authorized to provide by the protocols established by the local medical control authority under section 20919 for an emergency medical technician specialist.

(4) "Local governmental unit" means a county, city, village, charter township, or township.

(5) "Medical control" means supervising and coordinating emergency medical services through a medical control authority, as prescribed, adopted, and enforced through department-approved protocols, within an emergency medical services system.

(6) "Medical control authority" means an organization designated by the department under section 20910(1)(g) to provide medical control.

(7) "Medical director" means a physician who is appointed to that position by a medical control authority under section 20918.

(8) "Medical first responder" means an individual who has met the educational requirements of a department approved medical first responder course and who is licensed to provide medical first response life support as part of a medical first response service or as a driver of an ambulance that provides basic life support services only. Medical first responder does not include a police officer solely because his or her police vehicle is equipped with an automated external defibrillator.

(9) "Medical first response life support" means patient care that may include any care a medical first responder is qualified to provide by medical first responder education that meets the educational requirements established by the department under section 20912 or is authorized to provide by the protocols established by the local medical control authority under section 20919 for a medical first responder.

(10) "Medical first response service" means a person licensed by the department to respond under medical control to an emergency scene with a medical first responder and equipment required by the department before the arrival of an ambulance, and includes a fire suppression agency only if it is dispatched for medical first response life support. Medical first response service does not include a law enforcement agency, as defined in section 8 of 1968 PA 319, MCL 28.258, unless the law enforcement agency holds itself out as a medical first response service and the unit responding was dispatched to provide medical first response life support.

(11) "Medical first response vehicle" means a motor vehicle staffed by at least 1 medical first responder and meeting equipment requirements of the department. Medical first response vehicle does not include a vehicle solely because it is staffed with a medical first responder.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 6, Imd. Eff. Feb. 20, 2004;—Am. 2006, Act 582, Imd. Eff. Jan. 3, 2007.

Popular name: Act 368

333.20908 Definitions; N to V.

Sec. 20908. (1) "Nonemergency patient" means an individual who is transported by stretcher, isolette, cot, or litter but whose physical or mental condition is such that the individual may reasonably be suspected of not being in imminent danger of loss of life or of significant health impairment.

(2) "Nontransport prehospital life support operation" means a person licensed under this part to provide, for profit or otherwise, basic life support, limited advanced life support, or advanced life support at the scene of an emergency.

(3) "Nontransport prehospital life support vehicle" means a motor vehicle that is used to provide basic life support, limited advanced life support, or advanced life support, and is not intended to transport patients.

(4) "Ongoing education program sponsor" means an education program sponsor that provides continuing education for emergency medical services personnel.

(5) "Paramedic" means an individual licensed under this part to provide advanced life support.

(6) "Patient" means an emergency patient or a nonemergency patient.

(7) "Person" means a person as defined in section 1106 or a governmental entity other than an agency of the United States.

(8) "Professional standards review organization" means a committee established by a life support agency or a medical control authority for the purpose of improving the quality of medical care.

(9) "Protocol" means a patient care standard, standing orders, policy, or procedure for providing emergency medical services that is established by a medical control authority and approved by the department under section 20919.

(10) "Statewide emergency medical services communications system" means a system that integrates each emergency medical services system with a centrally coordinated dispatch and resource coordination facility utilizing the universal emergency telephone number, 9-1-1, when that number is appropriate, or any other designated emergency telephone number, a statewide emergency medical 2-way radio communications network, and linkages with the statewide emergency preparedness communications system.

(11) "Statewide trauma care system" means a comprehensive and integrated arrangement of the emergency services personnel, facilities, equipment, services, communications, medical control authorities, and organizations necessary to provide trauma care to all patients within a particular geographic region.

(12) "Volunteer" means an individual who provides services regulated under this part without expecting or receiving money, goods, or services in return for providing those services, except for reimbursement for expenses necessarily incurred in providing those services.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 581, Imd. Eff. Jan. 4, 2005.

Popular name: Act 368

333.20910 Powers and duties of department.

Sec. 20910. (1) The department shall do all of the following:

(a) Be responsible for the development, coordination, and administration of a statewide emergency medical services system.

(b) Facilitate and promote programs of public information and education concerning emergency medical services.

(c) In case of actual disasters and disaster training drills and exercises, provide emergency medical services resources pursuant to applicable provisions of the Michigan emergency preparedness plan, or as prescribed by the director of emergency services pursuant to the emergency management act, 1976 PA 390, MCL 30.401 to 30.421.

(d) Consistent with the rules of the federal communications commission, plan, develop, coordinate, and administer a statewide emergency medical services communications system.

(e) Develop and maintain standards of emergency medical services and personnel as follows:

(i) License emergency medical services personnel in accordance with this part.

(ii) License ambulance operations, nontransport prehospital life support operations, and medical first response services in accordance with this part.

(iii) At least annually, inspect or provide for the inspection of each life support agency, except medical first response services. As part of that inspection, the department shall conduct random inspections of life support vehicles. If a life support vehicle is determined by the department to be out of compliance, the department

shall give the life support agency 24 hours to bring the life support vehicle into compliance. If the life support vehicle is not brought into compliance in that time period, the department shall order the life support vehicle taken out of service until the life support agency demonstrates to the department, in writing, that the life support vehicle has been brought into compliance.

(iv) Promulgate rules to establish the requirements for licensure of life support agencies, vehicles, and individuals licensed under this part to provide emergency medical services and other rules necessary to implement this part. The department shall submit all proposed rules and changes to the state emergency medical services coordination committee and provide a reasonable time for the committee's review and recommendations before submitting the rules for public hearing under the administrative procedures act of 1969.

(f) Promulgate rules to establish and maintain standards for and regulate the use of descriptive words, phrases, symbols, or emblems that represent or denote that an ambulance operation, nontransport prehospital life support operation, or medical first response service is or may be provided. The department's authority to regulate use of the descriptive devices includes use for the purposes of advertising, promoting, or selling the services rendered by an ambulance operation, nontransport prehospital life support operation, or medical first response service, or by emergency medical services personnel.

(g) Designate a medical control authority as the medical control for emergency medical services for a particular geographic region as provided for under this part.

(h) Develop and implement field studies involving the use of skills, techniques, procedures, or equipment that are not included as part of the standard education for medical first responders, emergency medical technicians, emergency medical technician specialists, or paramedics, if all of the following conditions are met:

(i) The state emergency medical services coordination committee reviews the field study prior to implementation.

(ii) The field study is conducted in an area for which a medical control authority has been approved pursuant to subdivision (g).

(iii) The medical first responders, emergency medical technicians, emergency medical technician specialists, and paramedics participating in the field study receive training for the new skill, technique, procedure, or equipment.

(i) Collect data as necessary to assess the need for and quality of emergency medical services throughout the state pursuant to 1967 PA 270, MCL 331.531 to 331.533.

(j) Develop, with the advice of the emergency medical services coordination committee, an emergency medical services plan that includes rural issues.

(k) Develop recommendations for territorial boundaries of medical control authorities that are designed to assure that there exists reasonable emergency medical services capacity within the boundaries for the estimated demand for emergency medical services.

(l) Within 1 year after the statewide trauma care advisory subcommittee is established under section 20917a and in consultation with the statewide trauma care advisory subcommittee, develop, implement, and promulgate rules for the implementation and operation of a statewide trauma care system within the emergency medical services system consistent with the document entitled "Michigan Trauma Systems Plan" prepared by the Michigan trauma coalition, dated November 2003. The implementation and operation of the statewide trauma care system, including the rules promulgated in accordance with this subdivision, are subject to review by the emergency medical services coordination committee and the statewide trauma care advisory subcommittee. The rules promulgated under this subdivision shall not require a hospital to be designated as providing a certain level of trauma care. Upon implementation of a statewide trauma care system, the department shall review and identify potential funding mechanisms and sources for the statewide trauma care system.

(m) Promulgate other rules to implement this part.

(n) Perform other duties as set forth in this part.

(2) The department may do all of the following:

(a) In consultation with the emergency medical services coordination committee, promulgate rules to require an ambulance operation, nontransport prehospital life support operation, or medical first response service to periodically submit designated records and data for evaluation by the department.

(b) Establish a grant program or contract with a public or private agency, emergency medical services professional association, or emergency medical services coalition to provide training, public information, and assistance to medical control authorities and emergency medical services systems or to conduct other activities as specified in this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 200, Imd. Eff. July 12, 2004;—Am. 2004, Act 582, Imd. Eff. Jan. 4, 2005;—Am. 2006, Act 582, Imd. Eff. Jan. 3, 2007.

Popular name: Act 368

333.20911 Repealed. 2006, Act 582, Eff. Dec. 31, 2009.

Compiler's note: The repealed section pertained to equipping life support vehicle with automated external defibrillator.

333.20912 Duties of department with regard to educational programs and services.

Sec. 20912. (1) The department shall perform all of the following with regard to educational programs and services:

(a) Review and approve education program sponsors, ongoing education program sponsors, and curricula for emergency medical services personnel. Approved education programs and refresher programs shall be coordinated by a licensed emergency medical services instructor-coordinator commensurate with level of licensure. Approved programs conducted by ongoing education program sponsors shall be coordinated by a licensed emergency medical services instructor-coordinator.

(b) Maintain a listing of approved education program sponsors and licensed emergency medical services instructor-coordinators.

(c) Develop and implement standards for all education program sponsors and ongoing education program sponsors based upon criteria recommended by the emergency medical services coordination committee and developed by the department.

(2) An education program sponsor that conducts education programs for paramedics and that receives accreditation from the joint review committee on educational programs for the EMT-paramedic or other organization approved by the department as having equivalent expertise and competency in the accreditation of paramedic education programs is considered approved by the department under subsection (1)(a) if the education program sponsor meets both of the following requirements:

(a) Submits an application to the department that includes verification of accreditation described in this subsection.

(b) Maintains accreditation as described in this subsection.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20915 State emergency medical services coordination committee; creation; appointment, qualifications, and terms of members; ex officio members; replacement of member; chairperson; meetings; quorum; per diem compensation; reimbursement of expenses.

Sec. 20915. (1) The state emergency medical services coordination committee is created in the department. Subject to subsections (3) and (5), the director shall appoint the voting members of the committee as follows:

(a) Four representatives from the Michigan health and hospital association or its successor organization, at least 1 of whom is from a hospital located in a county with a population of not more than 100,000.

(b) Four representatives from the Michigan chapter of the American college of emergency physicians or its successor organization, at least 1 of whom practices medicine in a county with a population of not more than 100,000.

(c) Three representatives from the Michigan association of ambulance services or its successor organization, at least 1 of whom operates an ambulance service in a county with a population of not more than 100,000.

(d) Three representatives from the Michigan fire chiefs association or its successor organization, at least 1 of whom is from a fire department located in a county with a population of not more than 100,000.

(e) Two representatives from the society of Michigan emergency medical services technician instructor-coordinators or its successor organization, at least 1 of whom works in a county with a population of not more than 100,000.

(f) Two representatives from the Michigan association of emergency medical technicians or its successor organization, at least 1 of whom practices in a county with a population of not more than 100,000.

(g) One representative from the Michigan association of air medical services or its successor organization.

(h) One representative from the Michigan association of emergency medical services systems or its successor organization.

(i) Three representatives from a statewide organization representing labor that deals with emergency medical services, at least 1 of whom represents emergency medical services personnel in a county with a population of not more than 100,000 and at least 1 of whom is a member of the Michigan professional fire

fighters union or its successor organization.

(j) One consumer.

(k) One individual who is an elected official of a city, village, or township located in a county with a population of not more than 100,000.

(2) In addition to the voting members appointed under subsection (1), the following shall serve as ex officio members of the committee without the right to vote:

(a) One representative of the office of health and medical affairs of the department of management and budget, appointed by the director.

(b) One representative of the department of consumer and industry services, appointed by the director.

(c) One member of the house of representatives, appointed by the speaker of the house of representatives.

(d) One member of the senate, appointed by the senate majority leader.

(3) The representatives of the organizations described in subsection (1) shall be appointed from among nominations made by each of those organizations.

(4) The voting members shall serve for a term of 3 years. A member who is unable to complete a term shall be replaced for the balance of the unexpired term.

(5) At least 1 voting member shall be from a county with a population of not more than 35,000 and at least 1 voting member shall be from a city with a population of not less than 900,000.

(6) The committee shall annually select a voting member to serve as chairperson.

(7) Meetings of the committee are subject to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. Thirteen voting members constitute a quorum for the transaction of business.

(8) The per diem compensation for the voting members and a schedule for reimbursement of expenses shall be as established by the legislature.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20916 State emergency medical services coordination committee; duties.

Sec. 20916. The state emergency medical services coordination committee created in section 20915 shall do all of the following:

(a) Meet not less than twice annually at the call of the chairperson or the director.

(b) Provide for the coordination and exchange of information on emergency medical services programs and services.

(c) Act as liaison between organizations and individuals involved in the emergency medical services system.

(d) Make recommendations to the department in the development of a comprehensive statewide emergency medical services program.

(e) Advise the legislature and the department on matters concerning emergency medical services throughout the state.

(f) Issue opinions on appeals of medical control authority decisions under section 20919 and make recommendations based on those opinions to the department for the resolution of those appeals.

(g) Participate in educational activities, special studies, and the evaluation of emergency medical services as requested by the director.

(h) Advise the department concerning vehicle standards for ambulances.

(i) Advise the department concerning minimum patient care equipment lists.

(j) Advise the department on the standards required under section 20910(1)(f).

(k) Appoint, with the advice and consent of the department, a statewide quality assurance task force to review and make recommendations to the department concerning approval of medical control authority applications and revisions concerning protocols under section 20919 and field studies under section 20910(1)(h), and conduct other quality assurance activities as requested by the director. A majority of the members of the task force shall be individuals who are not currently serving on the committee. The task force shall report its decisions, findings, and recommendations to the committee and the department.

(l) Advise the department concerning requirements for curriculum changes for emergency medical services educational programs.

(m) Advise the department on minimum standards that each life support agency must meet for licensure under this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20917 Repealed. 2000, Act 440, Eff. July 1, 2004.

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Compiler's note: The repealed section pertained to the statewide trauma care commission.

333.20917a Statewide trauma care advisory subcommittee; establishment; membership; appointment; terms; chairperson; meetings; quorum; recommendations regarding funding sources; "rural county" defined.

Sec. 20917a. (1) The statewide trauma care advisory subcommittee is established under the emergency medical services coordination committee to advise and assist the department on all matters concerning the development, implementation, and promulgation of rules for the implementation and continuing operation of a statewide trauma care system. The subcommittee shall consist of 10 members appointed by the director, within 90 days after the effective date of the amendatory act that added this section, as follows:

- (a) Two trauma surgeons who are trauma center directors.
- (b) One trauma nurse coordinator.
- (c) One trauma registrar.
- (d) One emergency physician.

(e) Two administrative hospital representatives, 1 of whom represents a hospital designated as a level I or level II trauma center by the American college of surgeons committee on trauma and 1 of whom represents a hospital that is not designated as a level I or level II trauma center by the American college of surgeons committee on trauma.

(f) One life support agency manager who is a member of the emergency medical services coordination committee.

(g) Two medical control authority medical directors, 1 of whom represents a rural county and 1 of whom represents a nonrural county.

(2) The members shall serve for a term of 3 years. A member who is unable to complete a term shall be replaced for the balance of the unexpired term.

(3) The committee shall annually select a member to serve as chairperson.

(4) Meetings of the committee are subject to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. Six members constitute a quorum for the transaction of business.

(5) Recommendations regarding potential funding mechanisms and sources for the statewide trauma care system shall only be submitted to the department for consideration after a unanimous vote of all members of the statewide trauma care advisory subcommittee in support of those recommendations.

(6) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical areas as those terms are defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 FR p. 82238 (December 27, 2000).

History: Add. 2004, Act 580, Imd. Eff. Jan. 3, 2005.

Popular name: Act 368

333.20918 Local medical control authority; designation; participating hospitals and freestanding surgical outpatient facilities; adherence to protocols; administration; appointment and membership of advisory body; medical director; operation of medical control authority; accountability of life support agencies and licensed individuals.

Sec. 20918. (1) Each hospital licensed under part 215 and each freestanding surgical outpatient facility licensed under part 208 that operates a service for treating emergency patients 24 hours a day, 7 days a week and meets standards established by medical control authority protocols shall be given the opportunity to participate in the ongoing planning and development activities of the local medical control authority designated by the department and shall adhere to protocols for providing services to a patient before care of the patient is transferred to hospital personnel, to the extent that those protocols apply to a hospital or freestanding surgical outpatient facility. The department shall designate a medical control authority for each Michigan county or part of a county, except that the department may designate a medical control authority to cover 2 or more counties if the department and affected medical control authorities determine that the available resources would be better utilized with a multiple county medical control authority. In designating a medical control authority, the department shall assure that there is a reasonable relationship between the existing emergency medical services capacity in the geographical area to be served by the medical control authority and the estimated demand for emergency medical services in that area.

(2) A medical control authority shall be administered by the participating hospitals. A medical control authority shall accept participation in its administration by a freestanding surgical outpatient facility licensed under part 208 if the freestanding surgical outpatient facility operates a service for treating emergency patients 24 hours a day, 7 days a week determined by the medical control authority to meet the applicable standards

established by medical control authority protocols. Subject to subsection (4), the participating hospitals shall appoint an advisory body for the medical control authority that shall include, at a minimum, a representative of each type of life support agency and each type of emergency medical services personnel functioning within the medical control authority's boundaries.

(3) With the advice of the advisory body of the medical control authority appointed under subsection (2), a medical control authority shall appoint a medical director of the medical control authority. The medical director shall be a physician who is board certified in emergency medicine by a national organization approved by the department, or who practices emergency medicine and is certified in both advanced cardiac life support and advanced trauma life support by a national organization approved by the department, and who meets other standards set forth in department rules. The medical director is responsible for medical control for the emergency medical services system served by the medical control authority.

(4) No more than 10% of the membership of the advisory body of a medical control authority shall be employees of the medical director or of an entity substantially owned or controlled by the medical director.

(5) A designated medical control authority shall operate in accordance with the terms of its designation.

(6) Each life support agency and individual licensed under this part is accountable to the medical control authority in the provision of emergency medical services, as defined in protocols developed by the medical control authority and approved by the department under this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20919 Protocols for practice of life support agencies and licensed emergency medical services personnel; development and adoption; procedures; conflict with Michigan do-not-resuscitate procedure act prohibited; compliance with requirements; appeal; standards for equipment and personnel; negative medical or economic impacts; epinephrine auto-injector; availability of medical and economic information; review; findings.

Sec. 20919. (1) A local medical control authority shall establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within its region. The protocols shall be developed and adopted in accordance with procedures established by the department and shall include all of the following:

(a) The acts, tasks, or functions that may be performed by each type of emergency medical services personnel licensed under this part.

(b) Medical protocols to ensure the appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system.

(c) Protocols for complying with the Michigan do-not-resuscitate procedure act, 1996 PA 193, MCL 333.1051 to 333.1067.

(d) Protocols defining the process, actions, and sanctions a medical control authority may use in holding a life support agency or personnel accountable.

(e) Protocols to ensure that if the medical control authority determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control can immediately be taken until the medical control authority has had the opportunity to review the matter at a medical control authority hearing. The protocols shall require that the hearing is held within 3 business days after the medical control authority's determination.

(f) Protocols to ensure that if medical control has been removed from a participant in an emergency medical services system, the participant does not provide prehospital care until medical control is reinstated, and that the medical control authority that removed the medical control notifies the department within 1 business day of the removal.

(g) Protocols that ensure a quality improvement program is in place within a medical control authority and provides data protection as provided in 1967 PA 270, MCL 331.531 to 331.533.

(h) Protocols to ensure that an appropriate appeals process is in place.

(i) Within 1 year after December 23, 2003, protocols to ensure that each life support agency that provides basic life support, limited advanced life support, or advanced life support is equipped with epinephrine or epinephrine auto-injectors and that each emergency services personnel authorized to provide those services is properly trained to recognize an anaphylactic reaction, to administer the epinephrine, and to dispose of the epinephrine auto-injector or vial.

(j) Within 6 months after the effective date of the amendatory act that added this subdivision, protocols to ensure that each life support vehicle that is dispatched and responding to provide medical first response life

support, basic life support, or limited advanced life support is equipped with an automated external defibrillator and that each emergency services personnel is properly trained to utilize the automated external defibrillator.

(2) A protocol established under this section shall not conflict with the Michigan do-not-resuscitate procedure act, 1996 PA 193, MCL 333.1051 to 333.1067.

(3) The procedures established by the department for development and adoption of written protocols under this section shall comply with at least all of the following requirements:

(a) At least 60 days before adoption of a protocol, the medical control authority shall circulate a written draft of the proposed protocol to all significantly affected persons within the emergency medical services system served by the medical control authority and submit the written draft to the department for approval.

(b) The department shall review a proposed protocol for consistency with other protocols concerning similar subject matter that have already been established in this state and shall consider any written comments received from interested persons in its review.

(c) Within 60 days after receiving a written draft of a proposed protocol from a medical control authority, the department shall provide a written recommendation to the medical control authority with any comments or suggested changes on the proposed protocol. If the department does not respond within 60 days after receiving the written draft, the proposed protocol shall be considered to be approved by the department.

(d) After department approval of a proposed protocol, the medical control authority may formally adopt and implement the protocol.

(e) A medical control authority may establish an emergency protocol necessary to preserve the health or safety of individuals within its jurisdiction in response to a present medical emergency or disaster without following the procedures established by the department under this section for an ordinary protocol. An emergency protocol established under this subdivision is effective only for a limited time period and does not take permanent effect unless it is approved according to this subsection.

(4) A medical control authority shall provide an opportunity for an affected participant in an emergency medical services system to appeal a decision of the medical control authority. Following appeal, the medical control authority may affirm, suspend, or revoke its original decision. After appeals to the medical control authority have been exhausted, the affected participant in an emergency medical services system may appeal the medical control authority's decision to the statewide emergency medical services coordination committee. The statewide emergency medical services coordination committee shall issue an opinion on whether the actions or decisions of the medical control authority are in accordance with the department-approved protocols of the medical control authority and state law. If the statewide emergency medical services coordination committee determines in its opinion that the actions or decisions of the medical control authority are not in accordance with the medical control authority's department-approved protocols or with state law, the emergency medical services coordination committee shall recommend that the department take any enforcement action authorized under this code.

(5) If adopted in protocols approved by the department, a medical control authority may require life support agencies within its region to meet reasonable additional standards for equipment and personnel, other than medical first responders, that may be more stringent than are otherwise required under this part. If a medical control authority establishes additional standards for equipment and personnel, the medical control authority and the department shall consider the medical and economic impact on the local community, the need for communities to do long-term planning, and the availability of personnel. If either the medical control authority or the department determines that negative medical or economic impacts outweigh the benefits of those additional standards as they affect public health, safety, and welfare, protocols containing those additional standards shall not be adopted.

(6) If adopted in protocols approved by the department, a local medical control authority may require medical first response services and licensed medical first responders within its region to meet additional standards for equipment and personnel to ensure that each medical first response service is equipped with an epinephrine auto-injector, and that each licensed medical first responder is properly trained to recognize an anaphylactic reaction and to administer and dispose of the epinephrine auto-injector, if a life support agency that provides basic life support, limited advanced life support, or advanced life support is not readily available in that location.

(7) If a decision of the medical control authority under subsection (5) or (6) is appealed by an affected person, the medical control authority shall make available, in writing, the medical and economic information it considered in making its decision. On appeal, the statewide emergency medical services coordination committee shall review this information under subsection (4) and shall issue its findings in writing.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1996, Act 192, Eff. Aug. 1, 1996;—Am. 2000, Act 375, Imd. Eff. Jan. 2,

Popular name: Act 368

333.20920 Ambulance operation; license required; contents of application; fee; contents of license; operation of ambulance operation; renewal of license; compliance; ambulance operation upgrade license; statewide emergency medical coordination committee; report to legislature.

Sec. 20920. (1) A person shall not establish, operate, or cause to be operated an ambulance operation unless the ambulance operation is licensed under this section.

(2) Upon proper application and payment of a \$100.00 fee, the department shall issue a license as an ambulance operation to a person who meets the requirements of this part and the rules promulgated under this part.

(3) An applicant shall specify in the application each ambulance to be operated.

(4) An ambulance operation license shall specify the ambulances licensed to be operated.

(5) An ambulance operation license shall state the highest level of life support the ambulance operation is licensed to provide. An ambulance operation shall operate in accordance with this part, rules promulgated under this part, and approved medical control authority protocols and shall not provide life support at a level that exceeds its license and available licensed personnel or violates approved medical control authority protocols.

(6) An ambulance operation license may be renewed annually upon application to the department and payment of a \$100.00 renewal fee. Before issuing a renewal license, the department shall determine that the ambulance operation is in compliance with this part, the rules promulgated under this part, and medical control authority protocols.

(7) Beginning on July 22, 1997, an ambulance operation that meets all of the following requirements may apply for an ambulance operation upgrade license under subsection (8):

(a) On or before July 22, 1997, holds an ambulance operation license that designates the ambulance operation either as a transporting basic life support service or as a transporting limited advanced life support service.

(b) Is a transporting basic life support service, that is able to staff and equip 1 or more ambulances for the transport of emergency patients at a life support level higher than basic life support, or is a transporting limited advanced life support service, that is able to staff and equip 1 or more ambulances for the transport of emergency patients at the life support level of advanced life support.

(c) Is owned or operated by or under contract to a local unit of government and providing first-line emergency medical response to that local unit of government on or before July 22, 1997.

(d) Will provide the services described in subdivision (b) only to the local unit of government described in subdivision (c), and only in response to a 911 call or other call for emergency transport.

(8) An ambulance operation meeting the requirements of subsection (7) that applies for an ambulance operation upgrade license shall include all of the following information in the application provided by the department:

(a) Verification of all of the requirements of subsection (7) including, but not limited to, a description of the staffing and equipment to be used in providing the higher level of life support services.

(b) If the applicant is a transporting basic life support service, a plan of action to upgrade from providing basic life support to providing limited advanced life support or advanced life support to take place over a period of not more than 2 years. If the applicant is a transporting limited advanced life support service, a plan of action to upgrade from providing limited advanced life support to providing advanced life support to take place over a period of not more than 2 years.

(c) The medical control authority protocols for the ambulance operation upgrade license, along with a recommendation from the medical control authority under which the ambulance operation operates that the ambulance operation upgrade license be issued by the department.

(d) Other information required by the department.

(9) The statewide emergency medical services coordination committee shall review the information described in subsection (8)(c) and make a recommendation to the department as to whether or not an ambulance operation upgrade license should be granted to the applicant.

(10) Upon receipt of a completed application as required under subsection (8), a positive recommendation under subsection (9), and payment of a \$100.00 fee, the department shall issue to the applicant an ambulance operation upgrade license. Subject to subsection (12), the license is valid for 2 years from the date of issuance and is renewable for 1 additional 2-year period. An application for renewal of an ambulance operation upgrade license shall contain documentation of the progress made on the plan of action described in

subsection (8)(b). In addition, the medical control authority under which the ambulance operation operates shall annually file with the statewide emergency medical services coordination committee a written report on the progress made by the ambulance operation on the plan of action described in subsection (8)(b), including, but not limited to, information on training, equipment, and personnel.

(11) If an ambulance operation is designated by its regular license as providing basic life support services, then an ambulance operation upgrade license issued under this section allows the ambulance operation to provide limited advanced life support services or advanced life support services when the ambulance operation is able to staff and equip 1 or more ambulances to provide services at the higher levels. If an ambulance operation is designated by its regular license as providing limited advanced life support services, then an ambulance operation upgrade license issued under this section allows the ambulance operation to provide advanced life support services when the ambulance operation is able to staff and equip 1 or more ambulances to provide services at the higher level. An ambulance operation shall not provide services under an ambulance operation upgrade license unless the medical control authority under which the ambulance operation operates has adopted protocols for the ambulance operation upgrade license regarding quality monitoring procedures, use and protection of equipment, and patient care.

(12) The department may revoke or fail to renew an ambulance operation upgrade license for a violation of this part or a rule promulgated under this part or for failure to comply with the plan of action filed under subsection (8)(b). An ambulance operation that obtains an ambulance operation upgrade license must annually renew its regular license under subsections (2) to (6). An ambulance operation's regular license is not affected by the following:

(a) The fact that the ambulance operation has obtained or renewed an ambulance operation upgrade license.

(b) The fact that an ambulance operation's ambulance operation upgrade license is revoked or is not renewed under this subsection.

(c) The fact that the ambulance operation's ambulance operation upgrade license expires at the end of the second 2-year period prescribed by subsection (10).

(13) By July 22, 2000, the department shall file a written report to the legislature. The department shall include all of the following information in the report:

(a) The number of ambulance operations that were qualified under subsection (7) to apply for an ambulance operation upgrade license under subsection (8) during the 3-year period.

(b) The number of ambulance operations that in fact applied for an ambulance operation upgrade license during the 3-year period.

(c) The number of ambulance operations that successfully upgraded from being a transporting basic life support service to a transporting limited advanced service or a transporting advanced life support service or that successfully upgraded from being a transporting limited advanced life support service to a transporting advanced life support service under an ambulance operation upgrade license.

(d) The number of ambulance operations that failed to successfully upgrade, as described in subdivision (c), under an ambulance operation upgrade license, but that improved their services during the 3-year period.

(e) The number of ambulance operations that failed to successfully upgrade, as described in subdivision (c), under an ambulance operation upgrade license, and that showed no improvement or a decline in their services.

(f) The effect of the amendatory act that added this subsection on the delivery of emergency medical services in this state.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1997, Act 78, Imd. Eff. July 22, 1997;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 200, Imd. Eff. July 12, 2004.

Popular name: Act 368

333.20921 Ambulance operation; duties; prohibitions; occupants of patient compartment; operation at higher level of life support; applicability of subsection (5).

Sec. 20921. (1) An ambulance operation shall do all of the following:

(a) Provide at least 1 ambulance available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.

(b) Respond or ensure that a response is provided to each request for emergency assistance originating from within the bounds of its service area.

(c) Operate under the direction of a medical control authority or the medical control authorities with jurisdiction over the ambulance operation.

(d) Notify the department immediately of a change that would alter the information contained on its application for an ambulance operation license or renewal.

(e) Subject to section 20920(7) to (12), provide life support consistent with its license and approved local medical control authority protocols to each emergency patient without prior inquiry into ability to pay or source of payment.

(2) An ambulance operation shall not do 1 or more of the following:

(a) Knowingly provide a person with false or misleading information concerning the time at which an emergency response will be initiated or the location from which the response is being initiated.

(b) Induce or seek to induce any person engaging an ambulance to patronize a long-term care facility, mortuary, or hospital.

(c) Advertise, or permit advertising of, within or on the premises of the ambulance operation or within or on an ambulance, the name or the services of an attorney, accident investigator, nurse, physician, long-term care facility, mortuary, or hospital. If 1 of those persons or facilities owns or operates an ambulance operation, the person or facility may use its business name in the name of the ambulance operation and may display the name of the ambulance operation within or on the premises of the ambulance operation or within or on an ambulance.

(d) Advertise or disseminate information for the purpose of obtaining contracts under a name other than the name of the person holding an ambulance operation license or the trade or assumed name of the ambulance operation.

(e) If the ambulance operation is operating under an ambulance operation upgrade license issued under section 20920(7) to (12), advertise or otherwise hold itself out as a full-time transporting limited advanced life support service or a full-time transporting advanced life support service unless the ambulance operation actually provides those services on a 24-hour-per-day, 7-day-a-week basis.

(3) Except as provided in subsection (4), an ambulance operation shall not operate, attend, or permit an ambulance to be operated while transporting a patient unless the ambulance is, at a minimum, staffed as follows:

(a) If designated as providing basic life support, with at least 1 emergency medical technician and 1 medical first responder.

(b) If designated as providing limited advanced life support, with at least 1 emergency medical technician specialist and 1 emergency medical technician.

(c) If designated as providing advanced life support, with at least 1 paramedic and 1 emergency medical technician.

(4) An ambulance operation that is licensed to provide advanced life support and has more than 1 ambulance licensed under its operation may operate an ambulance licensed to provide basic life support or limited advanced life support at a higher level of life support if all of the following are met:

(a) The ambulance operation has at least 1 ambulance under its operation that is properly staffed and available to provide advanced life support on a 24-hour-a-day, 7-day-a-week basis.

(b) The licensed personnel required to operate at that higher level of life support are available at the scene and in the ambulance during the patient transport to provide life support to that patient at that higher level.

(c) The ambulance meets all equipment and communication requirements to operate at that higher level of life support.

(d) The ambulance operation that is unable to respond to a request for emergency assistance immediately requests assistance pursuant to protocols established by the local medical control authority and approved by the department under this part.

(5) Except as provided in subsection (6), an ambulance operation shall ensure that an emergency medical technician, an emergency medical technician specialist, or a paramedic is in the patient compartment of an ambulance while transporting an emergency patient.

(6) Subsection (5) does not apply to the transportation of a patient by an ambulance if the patient is accompanied in the patient compartment of the ambulance by an appropriate licensed health professional designated by a physician and after a physician-patient relationship has been established as prescribed in this part or the rules promulgated by the department under this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1997, Act 78, Imd. Eff. July 22, 1997;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 200, Imd. Eff. July 12, 2004.

Popular name: Act 368

333.20922 Use of terms “ambulance,” “ambulance operation,” or similar term; advertising or disseminating information; license required.

Sec. 20922. (1) A person shall not use the terms “ambulance” or “ambulance operation” or a similar term to describe or refer to the person unless the person is licensed by the department under section 20920.

(2) A person shall not advertise or disseminate information leading the public to believe that the person

provides an ambulance operation unless that person does in fact provide that service and has been licensed by the department to do so.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20923 Operation of ambulance; conditions; application for and issuance of ambulance license or annual renewal; fee; certificate of insurance; vehicle standards; minimum requirements for equipment; use of equipment or medications by licensed personnel; communications system; ambulance license nontransferable to ambulance operation.

Sec. 20923. (1) Except as provided in section 20924(2), a person shall not operate an ambulance unless the ambulance is licensed under this section and is operated as part of a licensed ambulance operation.

(2) Upon proper application and payment of a \$25.00 fee, the department shall issue an ambulance license, or annual renewal of an ambulance license, to the ambulance operation. Receipt of the application by the department serves as attestation to the department by the ambulance operation that the ambulance being licensed or renewed is in compliance with the minimum standards required by the department. The inspection of an ambulance by the department is not required as a basis for licensure renewal, unless otherwise determined by the department.

(3) An ambulance operation shall submit an application and fee to the department for each ambulance in service. Each application shall include a certificate of insurance for the ambulance in the amount and coverage required by the department.

(4) Upon purchase by an ambulance operation, an ambulance shall meet all vehicle standards established by the department under section 20910(e)(iv).

(5) Once licensed for service, an ambulance is not required to meet subsequently modified state vehicle standards during its use by the ambulance operation that obtained the license.

(6) Patient care equipment and safety equipment carried on an ambulance shall meet the minimum requirements prescribed by the department and the approved local medical control authority protocols.

(7) An ambulance operation that maintains patient care equipment and medications necessary to upgrade from providing basic or limited advanced life support to providing a higher level of life support in accordance with section 20921(4) shall secure the necessary patient care equipment and medications in a way such that the equipment or medications can only be used by the appropriately licensed personnel.

(8) An ambulance shall be equipped with a communications system utilizing frequencies and procedures consistent with the statewide emergency medical services communications system developed by the department.

(9) An ambulance license is not transferable to another ambulance operation.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 200, Imd. Eff. July 12, 2004.

Popular name: Act 368

333.20924 Business or service of transportation of patients; licensed ambulance required; exceptions.

Sec. 20924. (1) Except as provided in subsection (2), a person shall not furnish, operate, conduct, maintain, advertise, or otherwise be engaged or profess to be engaged in the business or service of the transportation of patients in this state unless the person uses an ambulance licensed under this part.

(2) An ambulance operated by an agency of the United States is not required to be licensed under this part. This part does not apply to an ambulance or ambulance personnel from another state or nation or a political subdivision of another state or nation that is performing in this state emergency assistance required by an official of this state.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20926 Nontransport prehospital life support operation; license required; application; fee; contents of license and application; renewal; compliance.

Sec. 20926. (1) A person shall not establish, operate, or cause to be operated a nontransport prehospital life support operation unless it is licensed under this section.

(2) The department, upon proper application and payment of a \$100.00 fee, shall issue a license for a nontransport prehospital life support operation to a person meeting the requirements of this part and rules promulgated under this part.

(3) A nontransport prehospital life support operation license shall specify the level of life support the

operation is licensed to provide. A nontransport prehospital life support operation shall operate in accordance with this part, rules promulgated under this part, and approved local medical control authority protocols and shall not provide life support at a level that exceeds its license or violates approved local medical control authority protocols.

(4) An applicant for a nontransport prehospital life support operation license shall specify in the application for licensure each nontransport prehospital life support vehicle to be operated.

(5) A nontransport prehospital life support operation license shall specify the nontransport prehospital life support vehicles licensed to be operated.

(6) A nontransport prehospital life support operation license may be renewed annually upon application to the department and payment of a \$100.00 renewal fee. Before issuing a renewal license, the department shall determine that the nontransport prehospital life support operation is in compliance with this part, rules promulgated under this part, and local medical control authority protocols.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20927 Nontransport prehospital life support operation; duties; prohibitions.

Sec. 20927. (1) A nontransport prehospital life support operation shall:

(a) Provide at least 1 nontransport prehospital life support vehicle with proper equipment and personnel available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.

(b) Respond or ensure that a response is provided to all requests for emergency assistance originating from within the bounds of its primary dispatch service area.

(c) Operate only under the direction of a medical control authority.

(d) Notify the department of any change that would alter the information contained on its application for a nontransport prehospital life support operation license or renewal.

(e) Provide life support consistent with its license and approved local medical control authority protocols to all patients without prior inquiry into ability to pay or source of payment.

(2) A nontransport prehospital life support operation shall not knowingly provide any person with false or misleading information concerning the time at which an emergency response will be initiated or the location from which the response is being initiated.

(3) A nontransport prehospital life support operation shall not operate a nontransport prehospital life support vehicle unless it is staffed, 24 hours a day, 7 days a week, as follows:

(a) If designated as providing basic life support, with at least 1 emergency medical technician who is on board that vehicle or if approved by the local medical control authority with at least 1 emergency medical technician who is at the emergency scene.

(b) If designated as providing limited advanced life support, with at least 1 emergency medical technician specialist.

(c) If designated as providing advanced life support, with at least 1 paramedic.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2005, Act 261, Imd. Eff. Dec. 16, 2005.

Popular name: Act 368

333.20928 Use of term “nontransport prehospital life support vehicle,” “nontransport prehospital life support operation,” or similar term; advertising or disseminating information; license required.

Sec. 20928. (1) A person shall not use the term “nontransport prehospital life support vehicle” or “nontransport prehospital life support operation” or a similar term to describe or refer to the person unless the person is licensed by the department under section 20926.

(2) A person shall not advertise or disseminate information leading the public to believe that the person provides a nontransport prehospital life support operation unless that person does in fact provide that service and has been licensed by the department to do so.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20929 Operation of nontransport prehospital life support vehicle; conditions; application for and issuance of license or annual renewal; fee; certificate of insurance; communications system; equipment.

Sec. 20929. (1) A person shall not operate a nontransport prehospital life support vehicle unless the vehicle is licensed by the department under this section and is operated as part of a licensed nontransport prehospital

life support operation.

(2) Upon proper application and payment of a \$25.00 fee, the department shall issue a nontransport prehospital life support vehicle license or annual renewal to the applicant nontransport prehospital life support operation. Receipt of the application by the department serves as attestation to the department by the nontransport prehospital life support operation that the vehicle being licensed or renewed is in compliance with the minimum standards required by the department. The inspection of a nontransport prehospital life support vehicle by the department is not required as a basis for issuing a licensure renewal, unless otherwise determined by the department.

(3) A nontransport prehospital life support operation shall submit an application and required fee to the department for each vehicle in service. Each application shall include a certificate of insurance for the vehicle in the amount and coverage required by the department.

(4) A nontransport prehospital life support vehicle shall be equipped with a communications system utilizing frequencies and procedures consistent with the statewide emergency medical services communications system developed by the department.

(5) A nontransport prehospital life support vehicle shall be equipped according to the department's minimum equipment list and approved medical control authority protocols based upon the level of life support the vehicle and personnel are licensed to provide.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20931 Air transport operation; license required; application; fee; issuance and contents of license; renewal; compliance.

Sec. 20931. (1) A person shall not establish, operate, or cause to be operated an aircraft transport operation unless it is licensed under this section.

(2) The department, upon proper application and payment of a \$100.00 fee, shall issue a license for an aircraft transport operation to a person meeting the requirements of this part and rules promulgated under this part.

(3) An aircraft transport operation license shall specify the level of life support the operation is licensed to provide. An aircraft transport operation shall operate in accordance with this part, rules promulgated under this part, and orders established by the patient's physician and shall not provide life support at a level that exceeds its license or violates those orders.

(4) An applicant for an aircraft transport operation license shall specify in the application for licensure each aircraft transport vehicle to be operated and licensed.

(5) An aircraft transport operation license may be renewed annually upon application to the department and payment of a \$100.00 renewal fee. Before issuing a renewal license, the department shall determine that the aircraft transport operation is in compliance with this part and rules promulgated under this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20932 Aircraft transport operation; duties; prohibitions.

Sec. 20932. (1) An aircraft transport operation shall:

(a) Provide an aircraft transport vehicle with proper equipment and personnel available for response to requests for patient transportation between health facilities, as needed and for life support during that transportation according to the written orders of the patient's physician.

(b) Notify the department of any change that would alter the information contained on its application for an aircraft transport operation license or renewal.

(2) An aircraft transport operation shall not operate an aircraft transport vehicle unless it is staffed, with emergency medical services personnel or other licensed health care professionals as appropriate according to the written orders of the patient's physician.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20933 Use of term “aircraft transport vehicle,” “aircraft transport operation,” or similar term; advertising or disseminating information; license required.

Sec. 20933. (1) A person shall not use the term “aircraft transport vehicle” or “aircraft transport operation” or a similar term to describe or refer to the person unless the person is licensed by the department under section 20931.

(2) A person shall not advertise or disseminate information leading the public to believe that the person

provides an aircraft transport operation unless that person does in fact provide that service and has been licensed by the department to do so.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20934 Operation of aircraft transport vehicle; conditions; application for and issuance of license or annual renewal; fee; certificate of insurance; communications system; equipment.

Sec. 20934. (1) A person shall not operate an aircraft transport vehicle unless the vehicle is licensed by the department under this section and is operated as part of a licensed aircraft transport operation.

(2) Upon proper application and payment of a \$100.00 fee, the department shall issue an aircraft transport vehicle license or annual renewal to the applicant aircraft transport operation. Receipt of the application by the department serves as attestation to the department by the aircraft transport operation that the vehicle is in compliance with the minimum standards required by the department. The inspection of an aircraft transport vehicle by the department is not required as a basis for licensure renewal, unless otherwise determined by the department.

(3) An aircraft transport operation shall submit an application and required fee to the department for each vehicle in service. Each application shall include a certificate of insurance for the vehicle in the amount and coverage required by the department.

(4) An aircraft transport vehicle shall be equipped with a communications system utilizing frequencies and procedures consistent with the statewide emergency medical services communications system developed by the department.

(5) An aircraft transport vehicle shall be equipped according to the department's minimum equipment list based upon the level of life support the vehicle and personnel are licensed to provide.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20935 Receipt of completed license application; issuance of license within certain period of time; report; “completed application” defined.

Sec. 20935. (1) Subject to subsection (3), beginning on the effective date of the amendatory act that added this section, the department shall approve or reject an initial license application for an ambulance operation, nontransport prehospital life support operation, aircraft transport operation, or medical first response service within 6 months after the applicant files a completed application as required under this part. Receipt of the application is considered the date the application is received by any agency or department of this state.

(2) If an initial license application for an ambulance operation, nontransport prehospital life support operation, aircraft transport operation, or medical first response service is considered incomplete by the department, the department shall notify the applicant in writing or make the notice electronically available within 30 days after receipt of the incomplete application, describing the deficiency and requesting additional information.

(3) If the department identifies a deficiency or requires the fulfillment of a corrective action plan, the 6-month period is tolled until either of the following occurs:

(a) Upon notification by the department of a deficiency, until the date the requested information is received by the department.

(b) Upon notification by the department that a corrective action plan is required, until the date the department determines the requirements of the corrective action plan have been met.

(4) The determination of the completeness of an application does not operate as an approval of the application for the license and does not confer eligibility of an applicant determined otherwise ineligible for issuance of a license.

(5) If the department fails to approve or reject an initial license application within the time period required under this section, the department shall return the license fee and shall reduce the license fee for the applicant's next licensure application, if any, by 15%. Failure to issue or deny a license within the time period required under this section does not allow the department to otherwise delay processing an application. The completed application shall be placed in sequence with other completed applications received at that same time. The department shall not discriminate against an applicant in the processing of the application based upon the fact that the application fee was refunded or discounted under this subsection.

(6) Beginning October 1, 2005, the director of the department shall submit a report by December 1 of each year to the standing committees and appropriations subcommittees of the senate and house of representatives

concerned with public health issues. The director shall include all of the following information in the report concerning the preceding fiscal year:

(a) The number of initial applications the department received and completed within the 6-month time period required under subsection (1).

(b) The number of applications requiring a request for additional information.

(c) The number of applications denied.

(d) The average processing time for initial licenses granted after the 6-month period.

(e) The number of initial license applications not issued within the 6-month period and the amount of money returned to applicants under subsection (5).

(7) As used in this section, "completed application" means an application complete on its face and submitted with any applicable licensing fees as well as any other information, records, approval, security, or similar item required by law or rule from a local unit of government, a federal agency, or a private entity but not from another department or agency of this state.

History: Add. 2004, Act 284, Imd. Eff. July 23, 2004.

Popular name: Act 368

333.20936 Application for license renewal received after expiration date of license; late fee; completing requirements for initial licensure.

Sec. 20936. (1) If an application for renewal of an ambulance operation, nontransport prehospital life support operation, or aircraft transport operation license is received by the department after the expiration date of the license, the applicant shall pay a late fee in the amount of \$300.00 in addition to the renewal fee. If an application for renewal is not received by the department within 60 days after the license expires, the department shall not issue a renewal license unless the licensee completes the requirements for initial licensure and pays the late fee.

(2) If an application for renewal of an ambulance or nontransport prehospital life support vehicle, or aircraft transport vehicle license is received by the department after the expiration date of the license, the applicant shall pay a late fee in the amount of \$100.00 in addition to the renewal fee. If an application for renewal is not received by the department within 60 days after the license expires, the department shall not issue a renewal license unless the licensee completes the requirements for initial licensure and pays the late fee.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20938 Operation of ambulance or nontransport prehospital life support vehicle under emergency conditions; privileges and constraints.

Sec. 20938. When operating an ambulance or a nontransport prehospital life support vehicle under emergency conditions or a reasonable belief that an emergency condition exists, the driver of the ambulance or nontransport prehospital life support vehicle may exercise the privileges and is subject to the constraints prescribed by the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, being sections 257.1 to 257.923 of the Michigan Compiled Laws, pertaining to the driver of an authorized emergency vehicle.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20939 Spontaneous use of vehicle under exceptional circumstances; written report.

Sec. 20939. If an ambulance operation is unable to respond to an emergency patient within a reasonable time, this part does not prohibit the spontaneous use of a vehicle under exceptional circumstances to provide, without charge or fee and as a humane service, transportation for the emergency patient. Emergency medical personnel who transport or who make the decision to transport an emergency patient under this section shall file a written report describing the incident with the medical control authority.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20941 Medical first response service; license required; issuance; requirements; duties; renewal of license; advertising or disseminating information; availability of vehicle; ability of patient to pay; police or fire suppression agency.

Sec. 20941. (1) A person shall not establish, operate, or cause to be operated a medical first response service unless the service is licensed by the department.

(2) Upon proper application, the department shall issue a license as a medical first response service to a

person who meets the requirements of this part and rules promulgated under this part. The department shall not charge a fee for licensing a medical first response service.

(3) A medical first response service shall provide life support in accordance with approved local medical control authority protocols and shall not provide life support at a level that exceeds its license or violates approved local medical control authority protocols.

(4) A medical first response service license may be renewed annually upon the application to the department.

(5) A person shall not advertise or disseminate information leading the public to believe that the person provides a medical first response service unless that person does in fact provide that service and has been licensed by the department.

(6) A medical first response service shall have at least 1 medical first response vehicle available on a 24-hour-a-day, 7-day-a-week basis, to provide a medical first response capability. Each medical first response vehicle shall be equipped and staffed as required by this part or rules promulgated under this part.

(7) A medical first response service shall provide life support consistent with its license and approved local medical control authority protocols to all patients without prior inquiry into ability to pay or source of payment.

(8) To the extent that a police or fire suppression agency is dispatched to provide medical first response life support, that agency is subject to this section and the other provisions of this part relating to medical first response services.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20945 Life support agency license; nonrenewable conditional license in lieu of denial, suspension, or revocation; duration; conditions.

Sec. 20945. If the department determines that grounds exist under section 20165 for denial, suspension, or revocation of a life support agency license but that the denial, suspension, or revocation of the license may be detrimental to the health, safety, and welfare of the residents served by the life support agency or applicant, the department may issue a nonrenewable conditional license effective for not more than 1 year and may prescribe such conditions as the department determines to be necessary to protect the public health, safety, and welfare.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20948 Operations and services furnished by local governmental unit; costs; ordinance.

Sec. 20948. (1) A local governmental unit or combination of local governmental units may operate an ambulance operation or a nontransport prehospital life support operation, or contract with a person to furnish any of those services for the use and benefit of its residents, and may pay for any or all of the cost from available funds. A local governmental unit may receive state or federal funds or private funds for the purpose of providing emergency medical services.

(2) A local governmental unit that operates an ambulance operation or a nontransport prehospital life support operation or is a party to a contract or an interlocal agreement may defray any or all of its share of the cost by either or both of the following methods:

(a) Collection of fees for services.

(b) Special assessments created, levied, collected, and annually determined pursuant to a procedure conforming as nearly as possible to the procedure set forth in section 1 of Act No. 33 of the Public Acts of 1951, being section 41.801 of the Michigan Compiled Laws. This procedure does not prohibit the right of referendum set forth under Act No. 33 of the Public Acts of 1951, being sections 41.801 to 41.811 of the Michigan Compiled Laws.

(3) A local governmental unit may enact an ordinance regulating ambulance operations, nontransport prehospital life support operations, or medical first response services. The standards and procedures established under the ordinance shall not be in conflict with or less stringent than those required under this part or the rules promulgated under this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20950 Medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or emergency medical services instructor-coordinator; licensing requirements; duration of license; examination or reexamination fees;

volunteers.

Sec. 20950. (1) An individual shall not practice or advertise to practice as a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or emergency medical services instructor-coordinator unless licensed to do so by the department.

(2) The department shall issue a license under this section only to an individual who meets all of the following requirements:

(a) Is 18 years of age or older.

(b) Has successfully completed the appropriate education program approved under section 20912.

(c) Subject to subsection (3), has attained a passing score on the appropriate department prescribed examination, as follows:

(i) A medical first responder shall pass the written examination proctored by the department or the department's designee and a practical examination approved by the department. The practical examination shall be administered by the instructors of the medical first responder course. The department or the department's designee may also proctor the practical examination.

(ii) An emergency medical technician, emergency medical technician specialist, and a paramedic shall pass the written examination proctored by the department or the department's designee and a practical examination proctored by the department or the department's designee.

(iii) The fee for the written examinations required under subparagraphs (i) and (ii) shall be paid directly to the national registry of emergency medical technicians or other organization approved by the department.

(d) Meets other requirements of this part.

(3) The department shall require for purposes of compliance with subsection (2)(c) successful passage by each first-time applicant of an examination as that term is defined in section 20904(10).

(4) The department shall issue a license as an emergency medical services instructor-coordinator only to an individual who meets the requirements of subsection (2) for an emergency medical services instructor-coordinator and at the time of application is currently licensed as a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic and has at least 3 years' field experience with a licensed life support agency as a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic. The department shall provide for the development and administration of an examination for emergency medical services instructor-coordinators. The license shall specify the level of instruction-coordination the individual is licensed to provide. An emergency medical services instructor-coordinator shall not instruct or coordinate emergency medical training courses at a level that exceeds his or her designated level of licensure and for which he or she does not have at least 3 years' field experience at that level of licensure.

(5) Except as provided by section 20952, a license under this section is effective for 3 years from the date of issuance unless revoked or suspended by the department.

(6) Except as otherwise provided in subsection (7), an applicant for licensure under this section shall pay the following triennial licensure fees:

(a) Medical first responder - no fee.

(b) Emergency medical technician - \$40.00.

(c) Emergency medical technician specialist - \$60.00.

(d) Paramedic - \$80.00.

(e) Emergency medical services instructor-coordinator - \$100.00.

(7) If a life support agency certifies to the department that an applicant for licensure under this section will act as a volunteer and if the life support agency does not charge for its services, the department shall not require the applicant to pay the fee required under subsection (6). If the applicant ceases to meet the definition of a volunteer under this part at any time during the effective period of his or her license and is employed as a licensee under this part, the applicant shall at that time pay the fee required under subsection (6).

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2006, Act 568, Imd. Eff. Jan. 3, 2007.

Popular name: Act 368

333.20952 Temporary license.

Sec. 20952. (1) The department may grant a nonrenewable temporary license to an individual who has made proper application with the required fee for licensure as a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic and who has successfully completed all of the requirements for licensure except for the department prescribed examinations. A temporary license is valid for 120 days from the date of an accepted application.

(2) An individual holding a temporary license as an emergency medical technician shall practice only

under the direct supervision of an emergency medical technician, emergency medical technician specialist, or paramedic who holds a license other than a temporary license.

(3) An individual holding a temporary license as an emergency medical technician specialist shall practice only under the direct supervision of an emergency medical technician specialist or paramedic who holds a license other than a temporary license.

(4) An individual holding a temporary license as a paramedic shall practice only under the direct supervision of a paramedic who holds a license other than a temporary license.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20954 Renewal license; renewal fees; procedures for late renewal; volunteers.

Sec. 20954. (1) Upon proper application to the department and payment of the renewal fee under subsection (2), the department may renew an emergency medical services personnel license if the applicant meets the requirements of this part and provides, upon request of the department, verification of having met ongoing education requirements established by the department. If an applicant for renewal fails to provide the department with a change of address, the applicant shall pay a \$20.00 fee in addition to the renewal and late fees required under subsections (2) and (3).

(2) Except as otherwise provided in subsection (5), an applicant for renewal of a license under section 20950 shall pay a renewal fee as follows:

- (a) Medical first responder - no fee.
- (b) Emergency medical technician - \$25.00.
- (c) Emergency medical technician specialist - \$25.00.
- (d) Paramedic - \$25.00.
- (e) Emergency medical services instructor-coordinator - \$25.00.

(3) Except as otherwise provided in subsection (5), if an application for renewal under subsection (1) is postmarked after the date the license expires, the applicant shall pay a late fee in addition to the renewal fee under subsection (2) as follows:

- (a) Medical first responder - \$50.00.
- (b) Emergency medical technician - \$50.00.
- (c) Emergency medical technician specialist - \$50.00.
- (d) Paramedic - \$50.00.
- (e) Emergency medical services instructor-coordinator - \$50.00.

(4) A license or registration shall be renewed by the licensee on or before the expiration date as prescribed by rule. The department shall mail a notice to the licensee at the last known address on file with the department advising of the time, procedure, and fee for renewal. Failure of the licensee to receive notice under this subsection does not relieve the licensee of the responsibility for renewing his or her license. A license not renewed by the expiration date may be renewed within 60 days of the expiration date upon application, payment of renewal and late renewal fees, and fulfillment of any continued continuing education requirements set forth in rules promulgated under this article. The licensee may continue to practice and use the title during the 60-day period. If a license is not so renewed within 60 days of the expiration date, the license is void. The licensee shall not practice or use the title. An individual may be relicensed within 3 years of the expiration date upon application, payment of the application processing, renewal, and late renewal fees, and fulfillment of any continuing education requirements in effect at the time of the expiration date, or that would have been required had the individual renewed his or her license pursuant to subsection (1). An individual may be relicensed more than 3 years after the expiration date upon application as a new applicant, meeting all licensure requirements in effect at the time of application, taking or retaking and passing any examinations required for initial licensure, and payment of fees required of new applicants.

(5) If a life support agency certifies to the department that an applicant for renewal under this section is a volunteer and if the life support agency does not charge for its services, the department shall not require the applicant to pay the fee required under subsection (2) or a late fee under subsection (3). If the applicant for renewal ceases to meet the definition of a volunteer under this part at any time during the effective period of his or her license renewal and is employed as a licensee under this part, the applicant for renewal shall at that time pay the fee required under subsection (2).

(6) An individual seeking renewal under this section is not required to maintain national registry status as a condition of license renewal.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 314, Eff. Jan. 1, 2001;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20956 Provision of life support; limitation; authorized techniques.

Sec. 20956. (1) A medical first responder, an emergency medical technician, an emergency medical technician specialist, or a paramedic shall not provide life support at a level that is inconsistent with his or her education, licensure, and approved medical control authority protocols.

(2) A medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic may perform techniques required in implementing a field study authorized under section 20910(1)(h) if he or she receives training for the skill, technique, procedure, or equipment involved in the field study.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20958 Emergency medical services personnel license; denial, revocation, or suspension; findings; notice; hearing order of circuit court to appear and give testimony.

Sec. 20958. (1) The department may deny, revoke, or suspend an emergency medical services personnel license upon finding that an applicant or licensee meets 1 or more of the following:

(a) Is guilty of fraud or deceit in procuring or attempting to procure licensure.

(b) Has illegally obtained, possessed, used, or distributed drugs.

(c) Has practiced after his or her license has expired or has been suspended.

(d) Has knowingly violated, or aided or abetted others in the violation of, this part or rules promulgated under this part.

(e) Is not performing in a manner consistent with his or her education, licensure, or approved medical control authority protocols.

(f) Is physically or mentally incapable of performing his or her prescribed duties.

(g) Has been convicted of a criminal offense under sections 520a to 520l of the Michigan penal code, 1931 PA 328, MCL 750.520a to 750.520l. A certified copy of the court record is conclusive evidence of the conviction.

(h) Has been convicted of a misdemeanor or felony reasonably related to and adversely affecting the ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence of the conviction.

(2) The department shall provide notice of intent to deny, revoke, or suspend an emergency services personnel license by certified mail or personal service. The notice of intent shall set forth the particular reasons for the proposed action and shall advise the applicant or licensee that he or she is entitled to the opportunity for a hearing before the director or the director's authorized representative. If the person to whom the notice is sent does not make a written request to the department for a hearing within 30 days of receiving the notice, the license is considered denied, revoked, or suspended as stated in the notice. If requested, the hearing shall be conducted pursuant to the administrative procedures act of 1969 and rules promulgated by the department. A full and complete record shall be kept of the proceeding and shall be transcribed when requested by an interested party, who shall pay the cost of preparing the transcript. On the basis of a hearing or on the default of the applicant or licensee, the department may issue, deny, suspend, or revoke a license.

(3) The department may establish procedures, hold hearings, administer oaths, issue subpoenas, or order testimony to be taken at a hearing or by deposition in a proceeding pending at any stage of the proceeding. A person may be compelled to appear and testify and to produce books, papers, or documents in a proceeding.

(4) In case of disobedience of a subpoena, a party to a hearing may invoke the aid of the circuit court of the jurisdiction in which the hearing is held to require the attendance and testimony of witnesses. The circuit court may issue an order requiring an individual to appear and give testimony. Failure to obey the order of the circuit court may be punished by the court as a contempt.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001;—Am. 2010, Act 304, Imd. Eff. Dec. 17, 2010.

Popular name: Act 368

333.20961 Reciprocity.

Sec. 20961. (1) The department may grant a license under this part to a person who is licensed in another state at the time of application if the applicant provides evidence satisfactory to the department as to all of the following:

(a) The applicant meets the requirements of this part and rules promulgated by the department for licensure.

(b) There are no pending disciplinary proceedings against the applicant before a similar licensing agency

of this or any other state or country.

(c) If sanctions have been imposed against the applicant by a similar licensing agency of this or any other state or country based upon grounds that are substantially similar to those set forth in section 20165 or 20958, as determined by the department, the sanctions are not in force at the time of the application.

(d) The other state maintains licensure standards equivalent to or more stringent than those of this state.

(2) The department may make an independent inquiry to determine whether an applicant meets the requirements described in subsection (1)(b) and (c).

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20963 Radio communications; compliance.

Sec. 20963. (1) A person participating in radio communications activities in support of emergency medical services, on frequencies utilized in the statewide emergency medical services communications system, shall comply with procedures and radio system requirements established by the department.

(2) A person who receives any intercepted public safety radio communication shall not utilize the contents of the communication for the purpose of initiating an emergency medical service response without the authorization of the sender. This subsection shall not apply to a radio communication generally transmitted to any listener by a person in distress.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20965 Immunity from liability.

Sec. 20965. (1) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, medical director of a medical control authority or his or her designee, or, subject to subsection (5), an individual acting as a clinical preceptor of a department-approved education program sponsor while providing services to a patient outside a hospital, in a hospital before transferring patient care to hospital personnel, or in a clinical setting that are consistent with the individual's licensure or additional training required by the medical control authority including, but not limited to, services described in subsection (2), or consistent with an approved procedure for that particular education program do not impose liability in the treatment of a patient on those individuals or any of the following persons:

(a) The authorizing physician or physician's designee.

(b) The medical director and individuals serving on the governing board, advisory body, or committee of the medical control authority and an employee of the medical control authority.

(c) The person providing communications services or lawfully operating or utilizing supportive electronic communications devices.

(d) The life support agency or an officer, member of the staff, or other employee of the life support agency.

(e) The hospital or an officer, member of the staff, nurse, or other employee of the hospital.

(f) The authoritative governmental unit or units.

(g) Emergency personnel from outside the state.

(h) The education program medical director.

(i) The education program instructor-coordinator.

(j) The education program sponsor and education program sponsor advisory committee.

(k) The student of a department-approved education program who is participating in an education program-approved clinical setting.

(l) An instructor or other staff employed by or under contract to a department-approved education program for the purpose of providing training or instruction for the department-approved education program.

(m) The life support agency or an officer, member of the staff, or other employee of the life support agency providing the clinical setting described in subdivision (k).

(n) The hospital or an officer, member of the medical staff, or other employee of the hospital providing the clinical setting described in subdivision (k).

(2) Subsection (1) applies to services consisting of the use of an automated external defibrillator on an individual who is in or is exhibiting symptoms of cardiac distress.

(3) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of any of the persons named below, while participating in the development of protocols under this part, implementation of protocols under this part, or holding a participant in the emergency medical services system accountable for department-approved protocols under this part, does not impose liability in the performance of those functions:

(a) The medical director and individuals serving on the governing board, advisory body, or committees of the medical control authority or employees of the medical control authority.

(b) A participating hospital or freestanding surgical outpatient facility in the medical control authority or an officer, member of the medical staff, or other employee of the hospital or freestanding surgical outpatient facility.

(c) A participating agency in the medical control authority or an officer, member of the medical staff, or other employee of the participating agency.

(d) A nonprofit corporation that performs the functions of a medical control authority.

(4) Subsections (1) and (3) do not limit immunity from liability otherwise provided by law for any of the persons listed in subsections (1) and (3).

(5) The limitation on liability granted to a clinical preceptor under subsection (1) applies only to an act or omission of the clinical preceptor relating directly to a student's clinical training activity or responsibility while the clinical preceptor is physically present with the student during the clinical training activity, and does not apply to an act or omission of the clinical preceptor during that time that indirectly relates or does not relate to the student's clinical training activity or responsibility.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1997, Act 78, Imd. Eff. July 22, 1997;—Am. 1999, Act 199, Imd. Eff. Dec. 20, 1999;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20967 Authority for management of emergency patient or management of scene of emergency; declaring nonexistence of emergency.

Sec. 20967. (1) Authority for the management of a patient in an emergency is vested in the licensed health professional or licensed emergency medical services personnel at the scene of the emergency who has the most training specific to the provision of emergency medical care. If a licensed health professional or licensed emergency medical services personnel is not available, the authority is vested in the most appropriately trained representative of a public safety agency at the scene of the emergency.

(2) When a life support agency is present at the scene of the emergency, authority for the management of an emergency patient in an emergency is vested in the physician responsible for medical control until that physician relinquishes management of the patient to a licensed physician at the scene of the emergency.

(3) Authority for the management of the scene of an emergency is vested in appropriate public safety agencies. The scene of an emergency shall be managed in a manner that will minimize the risk of death or health impairment to an emergency patient and to other individuals who may be exposed to the risks as a result of the emergency. Priority shall be given to the interests of those individuals exposed to the more serious remediable risks to life and health. Public safety officials shall ordinarily consult emergency medical services personnel or other authoritative health professionals at the scene in the determination of remediable risks.

(4) If an emergency has been declared, the declaration that an emergency no longer exists shall be made only by an individual licensed under this part or a health professional licensed under article 15 who has training specific to the provision of emergency medical services in accordance with protocols established by the local medical control authority.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20969 Objection to treatment or transportation.

Sec. 20969. This part and the rules promulgated under this part do not authorize medical treatment for or transportation to a hospital of an individual who objects to the treatment or transportation. However, if emergency medical services personnel, exercising professional judgment, determine that the individual's condition makes the individual incapable of competently objecting to treatment or transportation, emergency medical services may provide treatment or transportation despite the individual's objection unless the objection is expressly based on the individual's religious beliefs.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20971 Emergency preparedness act and MCL 30.261 not affected by part; references to former laws.

Sec. 20971. (1) This part does not supersede, limit, or otherwise affect the emergency preparedness act, Act No. 390 of the Public Acts of 1976, being sections 30.401 to 30.420 of the Michigan Compiled Laws, or Act No. 151 of the Public Acts of 1953, being section 30.261 of the Michigan Compiled Laws, dealing with

licenses for professional, mechanical, or other skills for persons performing civil defense, emergency, or disaster functions under those acts.

(2) A reference in any law to former Act No. 290 of the Public Acts of 1976; former Act No. 288 of the Public Acts of 1976; former Act No. 330 of the Public Acts of 1976; or former part 32, 203, or 207 of this act shall be considered a reference to this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20973 Emergency medical services to and cooperative agreements with other states.

Sec. 20973. This part does not deny emergency medical services to individuals outside of the boundaries of this state, or limit, restrict, or prevent a cooperative agreement for the provision of emergency medical services between this state or a political subdivision of this state and another state or a political subdivision of another state, a federal agency, or another nation or a political subdivision of another nation.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

333.20975 Rules generally.

Sec. 20975. The department may promulgate rules to implement this part.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20977 Rules considered as rescinded; exceptions.

Sec. 20977. (1) Except as otherwise provided in subsection (2), rules promulgated to implement former parts 32, 203, or 207 of this act and in effect on July 22, 1990 do not continue, and are considered as rescinded.

(2) Subsection (1) does not apply to rules that have been identified as being applicable within 6 months after the effective date of the amendatory act that added this subsection, as recommended by the department and approved by the statewide emergency medical services coordination committee.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20979 Prohibited use of fees.

Sec. 20979. The legislature shall not use the increase in the amount of fees charged under this part from the fees charged under former part 207 as a basis for reducing the amount of general fund money that is appropriated to the department.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990.

Popular name: Act 368

PART 210

HEALTH MAINTENANCE ORGANIZATIONS

333.21001-333.21099 Repealed. 1982, Act 354, Imd. Eff. Dec. 21, 1982;—1987, Act 149, Imd. Eff. Oct. 26, 1987;—1988, Act 315, Eff. Mar. 30, 1989;—1996, Act 472, Eff. Oct. 1, 1997;—2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 368

Popular name: HMO

PART 213

HOMES FOR THE AGED

333.21301 Definitions and principles of construction.

Sec. 21301. 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.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the

director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.21307 Exemptions.

Sec. 21307. This part does not authorize the medical supervision, regulation, or control of the remedial care or treatment of residents in a home for the aged operated for the adherents of a bona fide church or religious denomination who rely on treatment by prayer or spiritual means only in accordance with the creed or tenets of that church or denomination. The residents, personnel, or employees, other than food handlers, of the home are not required to submit to a medical or physical examination.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21311 License required; use of "home for aged" or similar term or abbreviation; minimum age for admission; waiver of age limitation; documentation; determination by director.

Sec. 21311. (1) A home for the aged shall be licensed under this article.

(2) "Home for the aged" or a similar term or abbreviation shall not be used to describe or refer to a health facility or agency unless the health facility or agency is licensed as a home for the aged by the department under this article.

(3) Except as otherwise provided in this subsection, a home for the aged shall not admit an individual under 60 years of age. Upon the request of a home for the aged and subject to subsection (4), the director shall waive the age limitation imposed by this subsection if the individual, the individual's guardian or other legal representative, if appointed, and the owner, operator, and governing body of the home for the aged, upon consultation with the individual's physician, agree on each of the following:

(a) The home for the aged is capable of meeting all of the individual's medical, social, and other needs as determined in the individual's plan of service.

(b) The individual will be compatible with the other residents of that home for the aged.

(c) The placement in that home for the aged is in the best interests of the individual.

(4) The owner, operator, and governing body of the home for the aged shall submit, with its request for a waiver, documentation to the director that supports each of the points of agreement necessary under subsection (3). Within 5 days after receipt of the information required under this subsection, the director shall determine if that documentation collectively substantiates each of the points of agreement necessary under subsection (3) and approve or deny the waiver. If denied, the director shall send a written notice of the denial and the reasons for denial to the requesting party.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1984, Act 311, Eff. Mar. 29, 1985;—Am. 2004, Act 74, Imd. Eff. Apr. 21, 2004.

Popular name: Act 368

333.21313 Owner, operator, and governing body of home for aged; responsibilities and duties; good moral character; issuance of license by department; criminal history check and criminal records check required; renewal of license; storage of fingerprints in automated fingerprint identification system database; convictions.

Sec. 21313. (1) The owner, operator, and governing body of a home for the aged are responsible for all phases of the operation of the home and shall assure that the home 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 assure the availability of emergency medical care required by a resident.

(3) The owner, operator, or member of the governing body of a home for the aged and the authorized representative shall be of good moral character.

(4) The department of human services 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 a home for the aged, if an individual, shall give written consent at the time of license application and the authorized representative shall 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 a home for the aged shall 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 of human services 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 2012 amendatory act that amended this subsection, all owners, operators, and members of the governing body of homes for the aged who have regular direct access to residents or who have on-site facility operational responsibilities and all authorized representatives shall comply with the requirements of this section.

(9) The department of human services 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 licensing or regulatory bureau of the department of human services. 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 2012 amendatory act that added this subsection, 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 a home for the aged 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 of human services. The department of human services 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 a home for the aged shall not be present in a home for the aged 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.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 2010, Act 381, Imd. Eff. Dec. 22, 2010;—Am. 2012, Act 51, Imd. Eff. Mar. 13, 2012.

Popular name: Act 368

333.21321 Bond required.

Sec. 21321. (1) Before issuance of a license under this article, the owner, operator, or governing body of

the applicant shall give a bond with a surety approved by the department. The bond shall insure the department for the benefit of the residents. The bond shall be conditioned that the applicant do all of the following:

- (a) Hold separately and in trust all resident funds deposited with the applicant.
- (b) Administer the funds on behalf of a resident in the manner directed by the depositor.
- (c) Render a true and complete account to the resident, the depositor, and the department when requested.
- (d) Account, on termination of the deposit, for all funds received, expended, and held on hand.

(2) The bond shall be in an amount equal to not less than 1-1/4 times the average balance of resident funds held during the prior year. The department may require an additional bond or permit filing of a bond in a lower amount, if the department determines that a change in the average balance has occurred or may occur. An applicant for a new license shall file a bond in an amount which the department estimates as 1-1/4 times the average amount of funds which the applicant, upon issuance of the license, is likely to hold during the first year of operation.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21325 Removal of resident from home for the aged; conditions.

Sec. 21325. If a resident of a home for the aged is receiving care in the facility in addition to the room, board, and supervised personal care specified in section 20106(3), as determined by a physician, the department shall not order the removal of the resident from the home for the aged if both of the following conditions are met:

- (a) The resident, the resident's family, the resident's physician, and the owner, operator, and governing body of the home for the aged consent to the resident's continued stay in the home for the aged.
- (b) The owner, operator, and governing body of the home for the aged commit to assuring that the resident receives the necessary additional services.

History: Add. 2000, Act 437, Imd. Eff. Jan. 9, 2001.

Popular name: Act 368

333.21331 Licensee considered consumer of tangible personal property.

Sec. 21331. A licensee of a home for the aged operated for profit is considered to be the consumer, and not the retailer, of tangible personal property purchased and used or consumed in operation of the home.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21332 Home for the aged; influenza vaccination.

Sec. 21332. A home for the aged shall offer each resident, or shall provide each resident with information and assistance in obtaining, an annual vaccination against influenza in accordance with the most recent recommendations of the advisory committee on immunization practices of the federal centers for disease control and prevention, as approved by the department of community health.

History: Add. 2000, Act 437, Imd. Eff. Jan. 9, 2001.

Popular name: Act 368

333.21333 Repealed. 2009, Act 188, Eff. May 1, 2010.

Compiler's note: The repealed section pertained to smoking policies in homes for the aged.

333.21335 Requirement of emergency generator system in home for the aged.

Sec. 21335. (1) Except as provided under subsection (2), a home for the aged seeking a license or a renewal of a license under this article shall have, at a minimum, an emergency generator system that during an interruption of the normal electrical supply is capable of both of the following:

- (a) Providing not less than 4 hours of service.
- (b) Generating enough power to provide lighting at all entrances and exits and to operate equipment to maintain fire detection, alarm, and extinguishing systems, telephone switchboards, heating plant controls, and other critical mechanical equipment essential to the safety and welfare of the residents, personnel, and visitors.

(2) A home for the aged that is licensed under this article on the effective date of the amendatory act that added this section is not required to comply with subsection (1) until that home for the aged undergoes any major building modification. As used in this section, "major building modification" means an alteration of walls that creates a new architectural configuration or revision to the mechanical or electrical systems that

significantly revises the design of the system or systems. Major building modification does not include normal building maintenance, repair, or replacement with equivalent components or a change in room function.

(3) A home for the aged that is exempt from compliance under subsection (2) shall notify the local medical control authority and the local law enforcement agency that it does not have an emergency generator on site. Until a home for the aged undergoes any major building modification as provided under subsection (2), a home for the aged that is exempt from compliance under subsection (2) shall file with the department a copy of the home for the aged's written policies and procedures and existing plans or agreements for emergency situations, including in the event of an interruption of the normal electrical supply.

(4) A home for the aged that fails to comply with this section is subject to a civil penalty of not more than \$2,000.00 for each violation. Each day a violation continues is a separate offense and shall be assessed a civil penalty of not less than \$500.00 for each day during which the failure continues.

History: Add. 2004, Act 397, Eff. Apr. 15, 2005.

Popular name: Act 368

PART 214 HOSPICES

333.21401 Definitions; principles of construction.

Sec. 21401. (1) As used in this part:

(a) "Home care" means a level of care provided to a patient that is consistent with the categories "routine home care" or "continuous home care" described in 42 C.F.R. 418.302(b)(1) and (2).

(b) "Hospice residence" means a facility that meets all of the following:

(i) Provides 24-hour hospice care to 2 or more patients at a single location.

(ii) Either provides inpatient care directly in compliance with this article and with the standards set forth in 42 C.F.R. 418.100 or provides home care as described in this article.

(iii) Is owned, operated, and governed by a hospice program that is licensed under this article and provides aggregate days of patient care on a biennial basis to not less than 51% of its hospice patients in their own homes. As used in this subparagraph, "home" does not include a residence established by a patient in a health facility or agency licensed under this article or a residence established by a patient in an adult foster care facility licensed under the adult foster care facility licensing act, Act No. 218 of the Public Acts of 1979, being sections 400.701 to 400.737 of the Michigan Compiled Laws.

(c) "Inpatient care" means a level of care provided to a patient that is consistent with the categories "inpatient respite care day" and "general inpatient care day" described in 42 C.F.R. 418.302(b)(3) and (4).

(2) 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.

History: Add. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1996, Act 267, Imd. Eff. June 12, 1996.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.21411 License for hospice or hospice residence required; exception; use of term "hospice"; representation as hospice residence; exemption from licensure; separate license for health facility or agency; activities of health facility or agency not restricted; inspections and concurrent issuance of licenses.

Sec. 21411. (1) Except as provided in subsection (5), a hospice or hospice residence shall be licensed as required under this article.

(2) The term "hospice" shall not be used to describe or refer to a health program or agency unless that program or agency is licensed as a hospice by the department as required under this article or is exempted from licensure as provided in subsection (5).

(3) A person shall not represent itself as a hospice residence unless that person is licensed as a hospice residence by the department as required under this article.

(4) A hospital, nursing home, home for the aged, county medical care facility, or any other health facility or agency that operates a hospice or hospice residence shall be licensed as a hospice or hospice residence under this article.

(5) A hospice is exempt from licensure under this article if the hospice meets all of the following requirements:

- (a) Provides services to not more than 7 patients per month on a yearly average.
- (b) Does not charge or receive fees for goods or services provided.
- (c) Does not receive third party reimbursement for goods or services provided.

(6) If a hospice provides inpatient services that meet the definition of a hospital, nursing home, home for the aged, county medical care facility, hospice residence, or other health facility or agency, the hospice or hospice residence shall obtain a separate license as required under this article for that hospital, nursing home, home for the aged, county medical care facility, hospice residence, or other health facility or agency.

(7) This part does not restrict an activity of a health facility or agency if the activity is permitted under the license held by that health facility or agency.

(8) If separate licensure is required under this section, the department may conduct inspections and issue the required licenses concurrently.

History: Add. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1984, Act 16, Imd. Eff. Mar. 1, 1984;—Am. 1996, Act 267, Imd. Eff. June 12, 1996.

Popular name: Act 368

333.21413 Duties of owner, operator, and governing body of hospice or hospice residence.

Sec. 21413. (1) The owner, operator, and governing body of a hospice or hospice residence licensed under this article:

(a) Are responsible for all phases of the operation of the hospice or hospice residence and for the quality of care and services rendered by the hospice or hospice residence.

(b) Shall cooperate with the department in the enforcement of this part, and require that the physicians and other personnel working in the hospice or hospice residence and for whom a license or registration is required be currently licensed or registered.

(c) Shall not discriminate because of race, religion, color, national origin, or sex, in the operation of the hospice or hospice residence including employment, patient admission and care, and room assignment.

(2) As a condition of licensure as a hospice residence, an applicant shall have been licensed under this article as a hospice and in compliance with the standards set forth in 42 C.F.R. part 418 for not less than the 2 years immediately preceding the date of application for licensure. A hospice residence licensed under this article may provide both home care and inpatient care at the same location. A hospice residence providing inpatient care shall comply with the standards in 42 C.F.R. 418.100.

(3) In addition to the requirements of subsections (1) and (2) and section 21415, the owner, operator, and governing body of a hospice residence that is licensed under this article and that provides care only at the home care level shall do all of the following:

(a) Provide 24-hour nursing services for each patient in accordance with the patient's hospice care plan as required under 42 C.F.R. part 418.

(b) Have an approved plan for infection control that includes making provisions for isolating each patient with an infectious disease.

(c) Obtain fire safety approval pursuant to section 20156.

(d) Equip each patient room with a device approved by the department for calling the staff member on duty.

(e) Design and equip areas within the hospice residence for the comfort and privacy of each patient and his or her family members.

(f) Permit patients to receive visitors at any hour, including young children.

(g) Provide individualized meal service plans in accordance with 42 C.F.R. 418.100(j).

(h) Provide appropriate methods and procedures for the storage, dispensing, and administering of drugs and biologicals pursuant to 42 C.F.R. 418.100(k).

History: Add. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1996, Act 267, Imd. Eff. June 12, 1996.

Popular name: Act 368

333.21415 Program of planned and continuous hospice care; direction of medical components; coordination, design, and provision of hospice services.

Sec. 21415. (1) A hospice or a hospice residence shall provide a program of planned and continuous hospice care, the medical components of which shall be under the direction of a physician.

(2) Hospice care shall consist of a coordinated set of services rendered at home or in hospice residence or other institutional settings on a continuous basis for individuals suffering from a disease or condition with a terminal prognosis. The coordination of services shall assure that the transfer of a patient from 1 setting to

another will be accomplished with a minimum disruption and discontinuity of care. Hospice services shall address the physical, psychological, social, and spiritual needs of the individual and shall be designed to meet the related needs of the individual's family through the periods of illness and bereavement. These hospice services shall be provided through a coordinated interdisciplinary team that may also include services provided by trained volunteers.

History: Add. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1996, Act 267, Imd. Eff. June 12, 1996.

Popular name: Act 368

333.21417 Disease or condition with terminal prognosis as prerequisite for admission to or retention for care.

Sec. 21417. An individual shall not be admitted to or retained for care by a hospice or a hospice residence unless the individual is suffering from a disease or condition with a terminal prognosis. An individual shall be considered to have a disease or condition with a terminal prognosis if, in the opinion of a physician, the individual's death is anticipated within 6 months after the date of admission to the hospice or hospice residence. If a person lives beyond a 6-month or less prognosis, the person is not disqualified from receiving continued hospice care.

History: Add. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1996, Act 267, Imd. Eff. June 12, 1996.

Popular name: Act 368

333.21419 Rules.

Sec. 21419. (1) Not later than 1 year after the effective date of this part, the department shall submit for a public hearing proposed rules necessary to implement and administer this part.

(2) The rules promulgated pursuant to subsection (1) shall not establish standards related to the credentials of an individual providing care in a hospice program, whether as an employee of a program or volunteer in a program, unless, with respect to the type of care the individual would provide in the hospice program, a license or other credential is required by law for an individual providing that care.

History: Add. 1980, Act 293, Eff. Mar. 31, 1981.

Popular name: Act 368

Administrative rules: R 325.13101 et seq. of the Michigan Administrative Code.

333.21420 Exemption of hospices from license fees and certificate of need fees; period.

Sec. 21420. Notwithstanding any other provision of this act, all hospices shall be exempt from license fees and certificate of need fees for 3 years after the first hospice is licensed under this article.

History: Add. 1980, Act 293, Eff. Mar. 31, 1981;—Am. 1982, Act 245, Imd. Eff. Sept. 23, 1982.

Popular name: Act 368

333.21421 Repealed. 1987, Act 149, Imd. Eff. Oct. 26, 1987.

Compiler's note: The repealed section provided for the expiration of this part.

Popular name: Act 368

PART 215 HOSPITALS

333.21501 Definitions and principles of construction.

Sec. 21501. 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.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.21511 License required; use of term "hospital."

Sec. 21511. (1) A hospital shall be licensed under this article.

(2) "Hospital" shall not be used to describe or refer to a health facility unless the health facility is licensed as a hospital by the department under this article. This section does not apply to a hospital licensed or

operated by the department of mental health or the federal government or to a veterinary hospital.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21513 Owner, operator, and governing body of hospital; responsibilities and duties generally.

Sec. 21513. The owner, operator, and governing body of a hospital licensed under this article:

(a) Are responsible for all phases of the operation of the hospital, selection of the medical staff, and quality of care rendered in the hospital.

(b) Shall cooperate with the department in the enforcement of this part, and require that the physicians, dentists, and other personnel working in the hospital who are required to be licensed or registered are in fact currently licensed or registered.

(c) Shall assure that physicians and dentists admitted to practice in the hospital are granted hospital privileges consistent with their individual training, experience, and other qualifications.

(d) Shall assure that physicians and dentists admitted to practice in the hospital are organized into a medical staff to enable an effective review of the professional practices in the hospital for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients. The review shall include the quality and necessity of the care provided and the preventability of complications and deaths occurring in the hospital.

(e) Shall not discriminate because of race, religion, color, national origin, age, or sex in the operation of the hospital including employment, patient admission and care, room assignment, and professional or nonprofessional selection and training programs, and shall not discriminate in the selection and appointment of individuals to the physician staff of the hospital or its training programs on the basis of licensure or registration or professional education as doctors of medicine, osteopathic medicine and surgery, or podiatry.

(f) Shall assure that the hospital adheres to medical control authority protocols according to section 20918.

(g) Shall assure that the hospital develops and maintains a plan for biohazard detection and handling.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1984, Act 327, Imd. Eff. Dec. 26, 1984;—Am. 1986, Act 174, Imd. Eff. July 7, 1986;—Am. 1987, Act 178, Imd. Eff. Nov. 19, 1987;—Am. 1989, Act 27, Eff. Dec. 31, 1989;—Am. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 1993, Act 79, Eff. Apr. 1, 1994;—Am. 2002, Act 125, Imd. Eff. Apr. 1, 2002.

Compiler's note: Section 3 of Act 174 of 1986 provides: "This amendatory act shall only apply to contested cases filed on or after July 1, 1986."

Popular name: Act 368

333.21515 Confidentiality of records, data, and knowledge.

Sec. 21515. The records, data, and knowledge collected for or by individuals or committees assigned a review function described in this article are confidential and shall be used only for the purposes provided in this article, shall not be public records, and shall not be available for court subpoena.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21521 Minimum standards and rules; practices.

Sec. 21521. A hospital shall meet the minimum standards and rules authorized by this article and shall endeavor to carry out practices that will further protect the public health and safety, prevent the spread of disease, alleviate pain and disability, and prevent premature death.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21523 Strictness of rules and standards.

Sec. 21523. (1) The rules for operation and maintenance of hospitals shall not be less strict than those required for certification of hospitals under part D of title XVIII of the social security act, chapter 531, 79 Stat. 313, 42 U.S.C. 1395x to 1395yy and 1395bbb to 1395ggg.

(2) The standards relating to construction, additions, modernization, or conversion of hospitals shall not be less strict than the standards contained in the document entitled "Minimum Design Standards for Health Care Facilities in Michigan" published by the department, dated March 1998.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 2002, Act 683, Imd. Eff. Dec. 30, 2002.

Popular name: Act 368

333.21527 Sexual assault evidence kit.

Sec. 21527. (1) If an individual alleges to a physician or other member of the attending or admitting staff of a hospital that within the preceding 24 hours the individual has been the victim of criminal sexual conduct under sections 520a to 520l of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being sections 750.520a to 750.520 l of the Michigan Compiled Laws, the attending health care personnel responsible for examining or treating the individual immediately shall inform the individual of the availability of a sexual assault evidence kit and, with the consent of the individual, shall perform or have performed on the individual the procedures required by the sexual assault evidence kit.

(2) For the purposes of this section, the administration of a sexual assault evidence kit is not a medical procedure.

(3) As used in this section, "sexual assault evidence kit" means a standardized set of equipment and written procedures approved by the department of state police which have been designed to be administered to an individual principally for the purpose of gathering evidence of sexual conduct, which evidence is of the type offered in court by the forensic science division of the department of state police for prosecuting a case of criminal sexual conduct under sections 520a to 520 l of the Michigan penal code, Act No. 328 of the Public Acts of 1931.

History: Add. 1988, Act 3, Imd. Eff. Feb. 5, 1988.

Popular name: Act 368

333.21529 Repealed. 2010, Act 23, Eff. Apr. 1, 2012.

Compiler's note: The repealed section pertained to establishment of seasonal influenza immunization policy.

333.21530 Repealed. 2010, Act 21, Eff. Apr. 1, 2012.

Compiler's note: The repealed section pertained to influenza immunization for individual admitted to hospital.

333.21531 Repealed. 1988, Act 315, Eff. Mar. 30, 1989.

Compiler's note: The repealed section pertained to smoking policy.

Popular name: Act 368

333.21532 Acknowledgment of parentage.

Sec. 21532. (1) A hospital shall provide to an unmarried mother of a live child born in that hospital an acknowledgment of parentage form that can be completed by the child's mother and father to acknowledge paternity of the child as provided in the acknowledgment of parentage act. The hospital shall provide to the parents the information developed as required by subsection (2) on the purpose and completion of the form and on the rights and responsibilities of the parents. Execution of an acknowledgment of parentage as provided in the acknowledgment of parentage act establishes the child's legal paternity. The hospital shall forward a completed acknowledgment of parentage to the state register for recording.

(2) The department shall develop and distribute free of charge to hospitals the acknowledgment of parentage form, the information on the purpose and completion of the form, and the information on the rights and responsibilities of the parents. The hospital shall provide assistance and training to hospital staff assigned responsibility for obtaining the forms, as appropriate. The acknowledgment of parentage form and information shall clearly state that completion of the form is voluntary on the part of the mother and father, and shall include all of the notices as provided in section 7 of the acknowledgment of parentage act. The hospital shall provide each parent with a copy of the completed form.

(3) A hospital is immune from civil or criminal liability for providing the form required by this section, the information developed as required by this section, or otherwise fulfilling its duties under this section.

History: Add. 1993, Act 116, Eff. Jan. 21, 1993;—Am. 1996, Act 6, Eff. June 1, 1996;—Am. 1996, Act 307, Eff. June 1, 1997.

Popular name: Act 368

333.21533 Acknowledgment of paternity.

Sec. 21533. Upon request, the department shall provide to an unmarried mother of a child or to a putative father an acknowledgment of parentage form that can be completed by the child's mother and father to acknowledge the child's paternity as provided in the acknowledgment of parentage act, 1996 PA 305, MCL 722.1001 to 722.1013. The department shall provide to the mother and putative father the information developed as required by section 21532 on the purpose and completion of the form and on the parents' rights and responsibilities.

History: Add. 1998, Act 332, Imd. Eff. Aug. 10, 1998.

Popular name: Act 368

333.21534 Hospice care information provided by hospital.

Sec. 21534. Upon the request of a patient, a patient's physician, a member of the patient's family, the patient's designated patient advocate, or the patient's legal guardian, a hospital shall provide information orally and in writing to the requesting party regarding hospice and palliative care services and the availability of hospice care in the area in which the hospital is located. The hospital shall provide the information whether or not the hospital provides hospice care.

History: Add. 2001, Act 219, Imd. Eff. Dec. 28, 2001.

Popular name: Act 368

333.21551 Temporary delicensure of beds; extension; form and contents of application; amended application; alternative use of space; plans; relicensing of beds; automatic and permanent delicensing; bed inventory; transfer of beds; use of beds to comply with bed reduction plan prohibited; definitions.

Sec. 21551. (1) A hospital licensed under this article and located in a nonurbanized area may apply to the department to temporarily delicense not more than 50% of its licensed beds for not more than 5 years.

(2) A hospital that is granted a temporary delicensure of beds under subsection (1) may apply to the department for an extension of temporary delicensure for those beds for up to an additional 5 years to the extent that the hospital actually met the requirements of subsection (6) during the initial period of delicensure granted under subsection (1). The department shall grant an extension under this subsection unless the department determines under part 222 that there is a demonstrated need for the delicensed beds in the subarea in which the hospital is located. If the department does not grant an extension under this subsection, the hospital shall request relicensure of the beds pursuant to subsection (7) or allow the beds to become permanently delicensed pursuant to subsection (8).

(3) Except as otherwise provided in this section, for a period of 90 days after January 1, 1991, if a hospital is located in a distressed area and has an annual indigent volume consisting of not less than 25% indigent patients, the hospital may apply to the department to temporarily delicense not more than 50% of its licensed beds for a period of not more than 2 years. Upon receipt of a complete application under this subsection, the department shall temporarily delicense the beds indicated in the application. The department shall not grant an extension of temporary delicensure under this subsection.

(4) An application under subsection (1) or (3) shall be on a form provided by the department. The form shall contain all of the following information:

- (a) The number and location of the specific beds to be delicensed.
- (b) The period of time during which the beds will be delicensed.
- (c) The alternative use proposed for the space occupied by the beds to be delicensed.

(5) A hospital that files an application under subsection (1) or (3) may file an amended application with the department on a form provided by the department. The hospital shall state on the form the purpose of the amendment. If the hospital meets the requirements of this section, the department shall so amend the hospital's original application.

(6) An alternative use of space made available by the delicensure of beds under this section shall not result in a violation of this article or the rules promulgated under this article. Along with the application, an applicant for delicensure under subsection (1) or (3) shall submit to the department plans that indicate to the satisfaction of the department that the space occupied by the beds proposed for temporary delicensure will be used for 1 or more of the following:

(a) An alternative use that over the proposed period of temporary delicensure would defray the depreciation and interest costs that otherwise would be allocated to the space along with the operating expenses related to the alternative use.

(b) To correct a licensing deficiency previously identified by the department.

(c) Nonhospital purposes including, but not limited to, community service projects, if the depreciation and interest costs for all capital expenditures that would otherwise be allocated to the space, as well as any operating costs related to the proposed alternative use, would not be considered as hospital costs for purposes of reimbursement.

(7) The department shall relicense beds that are temporarily delicensed under this section if all of the following requirements are met:

(a) The hospital files with the department a written request for relicensure not less than 90 days before the earlier of the following:

- (i) The expiration of the period for which delicensure was granted.
- (ii) The date upon which the hospital is requesting relicensure.

(iii) The last hospital license renewal date in the delicensure period.

(b) The space to be occupied by the relicensed beds is in compliance with this article and the rules promulgated under this article, including all licensure standards in effect at the time of relicensure, or the hospital has a plan of corrections that has been approved by the department.

(8) If a hospital does not meet all of the requirements of subsection (7) or if a hospital decides to allow beds to become permanently delicensed as described in subsection (2), then all of the temporarily delicensed beds shall be automatically and permanently delicensed effective on the last day of the period for which the department granted temporary delicensure.

(9) The department shall continue to count beds temporarily delicensed under this section in the department's bed inventory for purposes of determining hospital bed need under part 222 in the subarea in which the beds are located. The department shall indicate in the bed inventory which beds are licensed and which beds are temporary delicensed under this section. The department shall not include a hospital's temporarily delicensed beds in the hospital's licensed bed count.

(10) A hospital that is granted temporary delicensure of beds under this section shall not transfer the beds to another site or hospital without first obtaining a certificate of need.

(11) A hospital that has beds that are subject to a hospital bed reduction plan or to a department action to enforce this article shall not use beds temporarily delicensed under this section to comply with the bed reduction plan.

(12) As used in this section:

(a) "Distressed area" means a city that meets all of the following criteria:

(i) Had a negative population change from 1970 to the date of the 1980 federal decennial census.

(ii) From 1972 to 1989, had an increase in its state equalized valuation that is less than the statewide average.

(iii) Has a poverty level that is greater than the statewide average, according to the 1980 federal decennial census.

(iv) Was eligible for an urban development action grant from the United States department of housing and urban development in 1984 and was listed in 49 F.R. No. 28 (February 9, 1984) or 49 F.R. No. 30 (February 13, 1984).

(v) Had an unemployment rate that was higher than the statewide average for 3 of the 5 years from 1981 to 1985.

(b) "Indigent volume" means the ratio of a hospital's indigent charges to its total charges expressed as a percentage as determined by the department of social services after November 12, 1990, pursuant to chapter 8 of the department of social services guidelines entitled "medical assistance program manual".

(c) "Nonurbanized area" means an area that is not an urbanized area.

(d) "Urbanized area" means that term as defined by the office of federal statistical policy and standards of the United States department of commerce in the appendix entitled "general procedures and definitions", 45 F.R. p. 962 (January 3, 1980), which document is incorporated by reference.

History: Add. 1990, Act 259, Imd. Eff. Oct. 15, 1990;—Am. 1990, Act 331, Imd. Eff. Dec. 21, 1990.

Popular name: Act 368

333.21552 Hospital transition assistance program; purpose; elements; feasibility study; financing; advisory committee; report.

Sec. 21552. (1) The department, in cooperation with the state hospital finance authority, the office of health and medical affairs, and other state agencies considered appropriate by the department, shall develop recommendations regarding the appropriateness and feasibility of a state hospital transition assistance program to provide voluntary assistance to hospitals wanting to close, convert, or consolidate their facilities with another hospital, in order to eliminate excess capacity in a way that would maintain common access to critical health care services and assist displaced employees.

(2) The hospital transition assistance program described in subsection (1) shall include at least the following elements:

(a) Assistance in retiring all or some appropriate portion of the principal and interest applicable to the outstanding debt of a hospital applying to participate in the program.

(b) Assistance, through relocation or retraining, to workers displaced as a result of a hospital closure, conversion, or consolidation under the program.

(c) Maintenance of community access to critical health care services, especially for the uninsured and the underinsured, that might be endangered as a result of assistance provided under this program.

(d) As appropriate to hospitals wanting to close, convert, or consolidate, assistance with license termination, cessation of operations, and disposition of assets to help defray the outstanding indebtedness of a

hospital applying to participate in the program.

(3) The state hospital finance authority, after consultation with experts knowledgeable about the approaches listed in this section, shall contract for a study of the feasibility of the hospital transition assistance program elements as described in subsection (2). The feasibility study shall include at least all of the following information:

(a) The outstanding hospital bonded indebtedness and associated interest for all the hospitals in this state and the amounts payable in principal and interest per year until the bonds are retired.

(b) The financial benefits and costs to the state, health care purchasers, and other hospitals of assisting in defraying portions of that indebtedness and interest according to the different possible options.

(c) Criteria for prioritizing assistance to hospitals applying to participate in the program.

(d) Options for, and estimated benefits and costs of, providing relocation and retraining assistance to workers displaced by a hospital closure, conversion, or consolidation assisted by the program.

(e) In cases of proposed conversions or consolidations, the possibility of including a requirement that the assistance will result in a net reduction of beds at least equal to the number licensed to the hospital applying to participate in the program.

(f) Interest among hospitals and purchasers regarding participation in the program.

(4) The state hospital finance authority may expend up to \$250,000.00 from its operating fund to finance the feasibility study described in subsection (3) and to staff the advisory committee created in subsection (5).

(5) An advisory committee appointed by the director shall react to and comment on the feasibility study developed pursuant to subsection (3), and report to the governor and legislature on the appropriateness of pursuing the options described in the feasibility study. The committee shall be composed of 15 members equally divided among representatives of health consumers, health providers, and purchasers of health care.

(6) The feasibility study required under subsection (3) shall be completed within 9 months after the effective date of the contract for the feasibility study. The advisory committee established under subsection (5) shall submit its report to the governor and the legislature not later than 4 months after the advisory committee receives the feasibility study.

History: Add. 1990, Act 259, Imd. Eff. Oct. 15, 1990.

Compiler's note: For transfer of powers and duties of state hospital finance authority to Michigan finance authority, see E.R.O. No. 2010-2, compiled at MCL 124.194.

Popular name: Act 368

333.21561 Application for designation as rural community hospital; use of term "rural community hospital"; definition.

Sec. 21561. (1) After the effective date of the rules required under section 21563, a hospital with fewer than 100 licensed beds located in a nonurbanized area that is either licensed on or before the effective date of this section or is licensed after the effective date of this section and is located in a county that did not have a hospital on the effective date of this section may apply to the department for designation as a rural community hospital.

(2) The term "rural community hospital" shall not be used to describe or refer to a health facility or agency unless the health facility or agency is designated as a rural community hospital by the department.

(3) As used in this section, "nonurbanized area" means that term as defined in section 21551.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21562 Rural community hospital as limited service hospital; delivery of basic acute care services; rules implementing part; agreement to participate in medicaid program; definition; participation in federal medicare program; appointment, membership, and purpose of ad hoc advisory committee; transfer agreement.

Sec. 21562. (1) A hospital designated as a rural community hospital under section 21561 shall be a limited service hospital directed toward the delivery of not more than basic acute care services in order to assure appropriate access in the rural area.

(2) The rules promulgated to implement this part shall require that a hospital designated as a rural community hospital under section 21561 shall provide no more than the following services:

(a) Emergency care.

(b) Stabilization care for transfer to another facility.

(c) Inpatient care.

(d) Radiology and laboratory services.

(e) Ambulatory care.

- (f) Obstetrical services.
- (g) Outpatient services.
- (h) Other services determined as appropriate by the ad hoc advisory committee created in subsection (5).

(3) A rural community hospital shall enter into an agreement with the department of social services to participate in the medicaid program. As used in this subsection, "medicaid" means that term as defined in section 22207.

(4) A rural community hospital shall meet the conditions for participation in the federal medicare program under title XVIII of the social security act.

(5) Not later than 3 months after the effective date of this section, the director shall appoint an ad hoc advisory committee to develop recommendations for rules to designate the maximum number of beds and the services to be provided by a rural community hospital. In developing recommendations under this subsection, the ad hoc advisory committee shall review the provisions of the code pertaining to hospital licensure in order to determine those provisions that should apply to rural community hospitals. The director shall direct the committee to report its recommendations to the department within 12 months after the committee is appointed. The ad hoc advisory committee shall be appointed as follows:

(a) Twenty-five percent of the members shall be representatives from hospitals with fewer than 100 licensed beds.

(b) Twenty-five percent of the members shall be representatives from health care provider organizations other than hospitals.

(c) Twenty-five percent of the members shall be representatives from organizations whose membership includes consumers of rural health care services or members of local governmental units located in rural areas.

(d) Twenty-five percent of the members shall be representatives from purchasers or payers of rural health care services.

(6) A hospital designated as a rural community hospital under section 21561 shall develop and implement a transfer agreement between the rural community hospital and 1 or more appropriate referral hospitals.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21563 Rules for designation of rural community hospital, maximum number of beds, and services; showing designation on license; licensing and regulation of rural community hospital; applicable provisions of part 222; differential reimbursement.

Sec. 21563. (1) The department, in consultation with the ad hoc advisory committee appointed under section 21562, shall promulgate rules for designation of a rural community hospital, maximum number of beds, and the services provided by a rural community hospital. The director shall submit proposed rules, based on the recommendations of the committee, for public hearing not later than 6 months after receiving the report under section 21562(5).

(2) The designation as a rural community hospital shall be shown on a hospital's license and shall be for the same term as the hospital license. Except as otherwise expressly provided in this part or in rules promulgated under this section, a rural community hospital shall be licensed and regulated in the same manner as a hospital otherwise licensed under this article. The provisions of part 222 applicable to hospitals also apply to a rural community hospital and to a hospital designated by the department under federal law as an essential access community hospital or a rural primary care hospital. This part and the rules promulgated under this part do not preclude the establishment of differential reimbursement for rural community hospitals, essential access community hospitals, and rural primary care hospitals.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21564 Waiving applicability of specified licensure requirement; conditions; application for waiver; form; duration of waiver; definition.

Sec. 21564. (1) Upon request of a hospital with less than 100 beds located in a nonurbanized area, the department may waive the applicability of a specified licensure requirement if the department determines that strict compliance with the licensure requirement is not necessary to protect the public health, safety, and welfare in light of the health care provided by or in the hospital. The department may impose conditions upon a waiver under this section to protect the public health, safety, and welfare.

(2) An application for a waiver under this section shall be on a form provided by the department.

(3) A waiver granted by the department under this section shall not exceed 2 years, except that the department may renew the waiver for subsequent periods if the hospital continues to meet the requirements of

this section.

(4) As used in this section, “nonurbanized area” means that term as defined in section 21551.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21565 Mental health crisis stabilization program.

Sec. 21565. A hospital that has entered into a contract with a community mental health board may establish a mental health crisis stabilization program for voluntary admission with a maximum length of stay not to exceed 72 hours.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21566 Essential access community hospital; designation; purpose; eligibility requirements; modification of requirements.

Sec. 21566. (1) The department shall designate an eligible hospital as an essential access community hospital in order to qualify the facility for the essential access community hospital program under section 1820(e) of title XVIII of the social security act, 42 U.S.C. 1395i-4.

(2) To be eligible for designation as an essential access community hospital, a hospital shall meet all of the following requirements:

(a) Be located outside of a metropolitan statistical area, as defined by the United States office of management and budget.

(b) Be located more than 35 miles from an essential access community hospital, or a facility classified by the secretary of health and human services as a rural referral center or a regional referral center under section 1886 (d)(5)(c) of title XVIII of the social security act, 42 U.S.C. 1395ww.

(c) Have at least 75 inpatient beds or be located more than 35 miles from any other hospital.

(d) Have a transfer agreement with at least a facility designated as a rural primary care hospital under section 1820(f) of title XVIII of the social security act, 42 U.S.C. 1395i-4.

(e) Meet other requirements established by the department with the approval of the secretary of health and human services.

(f) Be a nonprofit or public hospital.

(3) The department may modify the requirements of subsection (2) in order to conform with changes in the federal requirements, or possible waivers, as provided in federal law or regulation for the designation of an essential access community hospital.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21567 Rural primary care hospital; designation; purpose; eligibility requirements; modification of requirements.

Sec. 21567. (1) The department shall designate an eligible hospital as a rural primary care hospital in order to qualify the facility for the essential access community hospital program, under section 1820(f) of title XVIII of the social security act, 42 U.S.C. 1395i-4.

(2) To be eligible for designation as a rural primary care hospital, a hospital shall meet all of the following requirements:

(a) Be located outside of a metropolitan statistical area, as defined by the United States office of management and budget.

(b) Make available 24-hour emergency services.

(c) Provide no more than 6 inpatient beds for providing inpatient care for a period not to exceed 72 hours to patients requiring stabilization before discharge or transfer to a hospital.

(d) Have a transfer agreement with at least an essential access community hospital designated under section 21566.

(e) Meet other requirements established by the department and approved by the secretary of health and human services.

(f) Be a nonprofit or public hospital.

(3) The department shall indicate preferential designation under this section for an eligible hospital that is located more than 30 minutes travel time away from the next closest hospital.

(4) The department may modify the requirements of subsection (2) in order to conform with changes in the federal requirements, or possible waivers, as provided in federal law or regulation for the designation of a rural primary care hospital.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21568 Rural health networks.

Sec. 21568. The center for rural health created under section 2612, as part of the development of the biennial rural health plan required under section 2223, shall develop a plan that provides for the creation of a set of rural health networks. Each rural health network shall consist, at a minimum, of 1 essential access community hospital, rural referral center, or regional referral center described in section 21566, and 1 rural primary care hospital as described in section 21567. Other rural health care providers including, but not limited to, primary care centers, community health centers, licensed nursing homes, and local public health departments may also be included in a rural health network for the purpose of developing a continuum of patient care.

History: Add. 1990, Act 252, Imd. Eff. Oct. 12, 1990.

Popular name: Act 368

333.21571 Rural hospital; eligibility requirements; definition.

Sec. 21571. (1) To be a rural hospital and qualify as an eligible hospital under the federal medicare rural hospital flexibility program, 42 USC 1395i-4, a hospital not located outside of a metropolitan statistical area as defined in 42 USC 1395ww shall be located in a city, village, or township with a population of no more than 12,000 and in a county with a population of no more than 110,000. Population is to be determined according to the official 2000 federal decennial census.

(2) A hospital that is determined to be a rural hospital under this section may be designated by the department as a critical provider to satisfy the eligibility requirements for certification as a critical access hospital.

(3) As used in this section, "rural hospital" means a hospital that is located outside of a metropolitan statistical area as defined in 42 USC 1395ww or that satisfies the criteria established under subsection (1).

History: Add. 2004, Act 444, Imd. Eff. Dec. 22, 2004.

PART 217 NURSING HOMES

333.21701 Meanings of words and phrases; general definitions and principles of construction.

Sec. 21701. (1) For purposes of this part, the words and phrases defined in sections 21702 to 21703 have the meanings ascribed to them in those sections.

(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.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Compiler's note: For transfer of powers and duties of the division of health facility licensing and certification in the bureau of health systems, division of federal support services, and the division of emergency medical services, with the exception of the division of managed care and division of health facility development, from the department of public health to the director of the department of commerce, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

For transfer of powers and duties of the bureau of health services from the department of consumer and industry services to the director of the department of community health by Type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.21702 Definitions; D to P.

Sec. 21702. (1) "Discharge" means the voluntary or involuntary movement of a patient out of a nursing home regardless of the individual's destination or reason for the movement.

(2) "Full-time" means being usually present in the nursing home or conducting or participating in activities directly related to the nursing home during the normal 40-hour business week.

(3) "Involuntary transfer" means a transfer not agreed to in writing by the patient or, in the case of a plenary guardianship, by the patient's legal guardian.

(4) "Medicaid" means the program for medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, and 1396i to 1396u, and administered by the department of social services under the social welfare act, Act No. 280 of the Public Acts of 1939, being sections 400.1 to 400.119b of the Michigan Compiled Laws.

(5) "Medical reasons" means a medical justification for either of the following:

(a) The transfer or discharge of a patient in accord with the written orders of the attending physician that is

written into the patient's clinical record by the physician in the progress notes.

(b) The transfer or discharge of a patient who is a medicaid recipient due to a change in level of care required by the patient and the fact that the nursing home or nursing care facility is not certified to provide the needed level of care.

(6) "Medicare" means that term as defined in section 2701.

(7) "Modification of a license" means an action by the department to alter the number of beds, the levels of care, the portions of the physical plant that may be operated or maintained by a licensee in a particular nursing home, or to restrict the nursing home from engaging in activity that violates this article or a rule promulgated under this article.

(8) "Negative case action" means an action taken by the department of social services to deny an application for medical assistance, cancel medical assistance, or reduce medical assistance coverage.

(9) "Nonpayment" means:

(a) Failure to collect from the patient or any other source the full amount of the facility charges to a nonmedicaid patient based on a written contract signed on or after that patient's admission to the facility.

(b) Failure to collect a medicaid patient's stipulated contribution toward his or her care.

(10) "Private pay rate" means the amount charged by a nursing home for the care of a patient who is not entitled to state or federal benefits for that patient's nursing home care.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1994, Act 73, Imd. Eff. Apr. 11, 1994.

Popular name: Act 368

333.21703 Definitions; P to W.

Sec. 21703. (1) "Patient" means a person who receives care or services at a nursing home.

(2) "Patient's representative" means a person, other than the licensee or an employee or person having a direct or indirect ownership interest in the nursing home, designated in writing by a patient or a patient's guardian for a specific, limited purpose or for general purposes, or, if a written designation of a representative is not made, the guardian of the patient.

(3) "Relocation" means the movement of a patient from 1 bed to another or from 1 room to another within the same nursing home or within a certified distinct part of a nursing home.

(4) "Transfer" means the movement of a patient from 1 nursing home to another nursing home or from 1 certified distinct part of a nursing home to another certified distinct part of the same nursing home.

(5) "Welfare" means, with reference to a patient, the physical, emotional, or social well-being of a patient in a nursing home, including a patient awaiting transfer or discharge, as documented in the patient's clinical record by a licensed or certified health care professional.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21707 Prescribing course of medical treatment; limitations on authority.

Sec. 21707. (1) The course of medical treatment provided to a patient in a nursing home shall be prescribed by the patient's physician.

(2) This part does not:

(a) Authorize the supervision, regulation, or control of the practice of any method of healing.

(b) Authorize the medical supervision, regulation, or control of the remedial care or nonmedical nursing care of patients in a nursing home operated for the adherents of a bona fide church or religious denomination who rely upon treatment by prayer or spiritual means only in accordance with the creed or tenets of that church or denomination. The residents, patients, personnel, or employees, other than food handlers, of the home are not required to submit to a medical or physical examination. However, the nursing home shall be inspected and licensed under laws pertaining to fire, safety, sanitation, and building construction.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21711 License required; prohibited terms or abbreviations; license for formal or informal nursing care services; exception.

Sec. 21711. (1) A nursing home shall be licensed under this article.

(2) "Nursing home", "nursing center", "convalescent center", "extended care facility", or a similar term or abbreviation shall not be used to describe or refer to a health facility or agency unless the health facility or agency is licensed as a nursing home by the department under this article.

(3) A person shall not purport to provide formal or informal nursing care services of the kind normally provided in a nursing home without obtaining a license as provided in this article. This subsection does not

apply to a hospital or a facility created by Act No. 152 of the Public Acts of 1885, as amended, being sections 36.1 to 36.12 of the Michigan Compiled Laws.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21712 Name of nursing home; change in name; prohibited terms; rehabilitation services.

Sec. 21712. (1) A nursing home shall use the name that appears on the license for its premises. A nursing home shall not change its name without the approval of the department.

(2) A nursing home shall not use the terms “hospital” or “sanitarium” or a term conveying a meaning that is substantially similar to those terms in the name of the nursing home. However, a nursing home may use the term “health center” or “health care center” or “rehabilitation center” or a term conveying a meaning substantially similar to those terms as long as those terms do not conflict with the terms prohibited by this subsection.

(3) If a nursing home uses the term “rehabilitation center” in its name as allowed under subsection (2), the nursing home shall have the capacity to provide rehabilitation services that include, at a minimum, all of the following:

- (a) Physical therapy services.
- (b) Occupational therapy services.
- (c) Speech therapy services.

(4) A nursing home shall not include in its name the name of a religious, fraternal, or charitable corporation, organization, or association unless the corporation, organization, or association is an owner of the nursing home.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2001, Act 273, Imd. Eff. Jan. 11, 2002.

Popular name: Act 368

333.21713 Owner, operator, and governing body of nursing home; responsibilities and duties generally.

Sec. 21713. The owner, operator, and governing body of a nursing home licensed under this article:

(a) Are responsible for all phases of the operation of the nursing home and quality of care rendered in the home.

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

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21715 Programs of planned and continuing nursing and medical care required; nurses and physicians in charge; expiration of subsection (1)(a); nature and scope of services.

Sec. 21715. (1) A nursing home shall provide:

(a) A program of planned and continuing nursing care under the charge of a registered nurse in a skilled facility and a licensed practical nurse with a registered nurse consultant in an intermediate care facility. This subdivision shall expire December 31, 1979.

(b) A program of planned and continuing medical care under the charge of physicians.

(2) Nursing care and medical care shall consist of services given to individuals who are subject to prolonged suffering from illness or injury or who are recovering from illness or injury. The services shall be within the ability of the home to provide and shall include the functions of medical care such as diagnosis and treatment of an illness; nursing care via assessment, planning, and implementation; evaluation of a patient's health care needs; and the carrying out of required treatment prescribed by a physician.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21716 Nursing home; influenza vaccination.

Sec. 21716. A nursing home shall offer each resident, or shall provide each resident with information and assistance in obtaining, an annual vaccination against influenza in accordance with the most recent recommendations of the advisory committee on immunization practices of the federal centers for disease control and prevention, as approved by the department of community health.

History: Add. 2000, Act 437, Imd. Eff. Jan. 9, 2001.

Popular name: Act 368

333.21717 Individuals excluded from nursing home; exception; approval of area and program.

Sec. 21717. An individual shall not be admitted or retained for care in a nursing home who requires special medical or surgical treatment, or treatment for acute mental illness, mental retardation, communicable tuberculosis, or a communicable disease, unless the home is able to provide an area and a program for the care. The department shall approve both the area and the program, except for the programs providing treatment for mental illness and mental retardation which shall be approved by the department of mental health.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21718 Conditions of skilled nursing facility certification and participation in title 19 program; exception; exemption.

Sec. 21718. (1) Except as provided in subsections (3) and (4), as a condition of skilled nursing facility certification and participation in the title 19 program of the social security act, 42 U.S.C. 1396 to 1396k, a nursing home shall be concurrently certified for and give evidence of active participation in the title 18 program of the social security act, 42 U.S.C. 1395 to 1395qq. A nursing facility that is not concurrently certified for the title 18 program on the effective date of this section shall make application for concurrent certification not later than its next application for licensure and certification. A failure to make application shall result in the skilled nursing facility being decertified or refused certification as a provider in the title 19 program. Nursing home or nursing care facility participation in the title 18 program under the requirements for concurrent certification shall be effective not later than the beginning of the first accounting year following the home's or facility's title 18 certification.

(2) As a condition of skilled nursing facility certification, a nursing home shall obtain concurrent certification under title 19 of the social security act, 42 U.S.C. 1396 to 1396k, for each bed which is certified to provide skilled care under title 18 of the social security act, 42 U.S.C. 1395 to 1395qq. Skilled care certification shall not be renewed unless the requirements of this subsection are met.

(3) An exception may be made from the requirements of subsection (1) for a nursing facility that is currently certified as a skilled nursing facility by the director for title 19 participation but has been determined, after making application, to be ineligible for title 18 certification by the secretary of the United States department of health, education, and welfare.

(4) A home or facility, or a distinct part of a home or facility, certified by the director as a special mental retardation or special mental illness nursing home or nursing care facility shall be exempt from the requirements of subsection (1).

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21719 Immediate access to acute care facilities.

Sec. 21719. A nursing home shall not be licensed under this part unless the nursing home has formulated, and is prepared to implement, insofar as possible, a plan to provide immediate access to acute care facilities for the emergency care of patients.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21720 Nursing home administrator required.

Sec. 21720. (1) The department shall not license a nursing home under this part unless that nursing home is under the direction of a nursing home administrator licensed under article 15.

(2) Each nursing home having 50 beds or more shall have a full-time licensed nursing home administrator. If a nursing home changes nursing home administrators, the nursing home immediately shall notify the department of the change.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2001, Act 139, Imd. Eff. Oct. 26, 2001.

Popular name: Act 368

333.21720a Director of nursing; nursing personnel; effective date of subsection (1); natural disaster or other emergency.

Sec. 21720a. (1) A nursing home shall not be licensed under this part unless that nursing home has on its

staff at least 1 registered nurse with specialized training or relevant experience in the area of gerontology, who shall serve as the director of nursing and who shall be responsible for planning and directing nursing care. The nursing home shall have at least 1 licensed nurse on duty at all times and shall employ additional registered and licensed practical nurses in accordance with subsection (2). This subsection shall not take effect until January 1, 1980.

(2) A nursing home shall employ nursing personnel sufficient to provide continuous 24-hour nursing care and services sufficient to meet the needs of each patient in the nursing home. Nursing personnel employed in the nursing home shall be under the supervision of the director of nursing. A licensee shall maintain a nursing home staff sufficient to provide not less than 2.25 hours of nursing care by employed nursing care personnel per patient per day. The ratio of patients to nursing care personnel during a morning shift shall not exceed 8 patients to 1 nursing care personnel; the ratio of patients to nursing care personnel during an afternoon shift shall not exceed 12 patients to 1 nursing care personnel; and the ratio of patients to nursing care personnel during a nighttime shift shall not exceed 15 patients to 1 nursing care personnel and there shall be sufficient nursing care personnel available on duty to assure coverage for patients at all times during the shift. An employee designated as a member of the nursing staff shall not be engaged in providing basic services such as food preparation, housekeeping, laundry, or maintenance services, except in an instance of natural disaster or other emergency reported to and concurred in by the department. In a nursing home having 30 or more beds, the director of nursing shall not be included in counting the minimum ratios of nursing personnel required by this subsection.

(3) In administering this section, the department shall take into consideration a natural disaster or other emergency.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21720b Agreement with county community mental health program.

Sec. 21720b. A nursing home shall not be licensed under this part unless that nursing home has entered into an agreement with the county community mental health program, if available, that will service the mental health needs of the patients of the nursing home.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21721 Bond required.

Sec. 21721. (1) Before issuance or renewal of a nursing home license under this article, the owner, operator, or governing body of the nursing home shall give a bond and provide evidence of a patient trust fund in an amount consistent with subsection (2) and with the surety the department approves. The bond shall be conditioned that the applicant shall hold separately in the trust fund all patients' funds deposited with the applicant, shall administer the funds on behalf of the patient in the manner directed by the depositor, shall render a true and complete account to the patient not less than once each 3 months, to the depositor when requested, and to the department of public health and the department of social services, when requested. Upon termination of the deposit, the applicant shall account for all funds received, expended, and held on hand. The bond shall insure the department of public health, for the benefit of the patients.

(2) The bond shall be in an amount equal to not less than 1-1/4 times the average balance of patient funds held during the previous year. The department may require an additional bond, or permit the filing of a bond in a lower amount, if the department determines a change in the average balance has occurred or may occur. An applicant for a new license shall file a bond in an amount which the department estimates as 1-1/4 times the average amount of patient funds which the applicant, upon the issuance of the license, is likely to hold during the first year of operation.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21723 Individual responsible for receiving complaints and conducting investigations; posting information in nursing home; communication procedure; information posted on internet website; nursing home receiving medicaid reimbursement.

Sec. 21723. (1) A nursing home shall post in an area accessible to residents, employees, and visitors the name, title, location, and telephone number of the individual in the nursing home who is responsible for receiving complaints and conducting complaint investigations and a procedure for communicating with that individual.

(2) An individual responsible for receiving complaints and conducting complaint investigations in a

nursing home shall be on duty and on site not less than 24 hours per day, 7 days a week.

(3) The individual described in subsection (2) who receives a complaint, inquiry, or request from a nursing home resident or the resident's surrogate decision maker shall respond using the nursing home's established procedures pursuant to R 325.20113 of the Michigan administrative code.

(4) To assist the individual described in subsection (2) in performing his or her duties, the department of consumer and industry services shall post on its internet website all of the following information:

(a) Links to federal and state regulations and rules governing the nursing home industry.

(b) The scheduling of any training or joint training sessions concerning nursing home or elderly care issues being put on by the department of consumer and industry services.

(c) A list of long-term care contact phone numbers including, but not limited to, the consumer and industry services complaint hotline, the consumer and industry services nursing home licensing division, any commonly known nursing home provider groups, the state long-term care ombudsman, and any commonly known nursing home patient care advocacy groups.

(d) When it becomes available, information on the availability of electronic mail access to file a complaint concerning nursing home violations directly with the department of consumer and industry services.

(e) Any other information that the department of consumer and industry services believes is helpful in responding to complaints, requests, and inquiries of a nursing home resident or his or her surrogate decision maker.

(5) A nursing home receiving reimbursement pursuant to the medicaid program shall designate 1 or more current employees to fulfill the duties and responsibilities outlined in this section. This section does not constitute a basis for increasing nursing home staffing levels. As used in this subsection, "medicaid" means the program for medical assistance created under title XIX of the social security act, chapter 53, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v.

History: Add. 2002, Act 11, Imd. Eff. Feb. 19, 2002.

Popular name: Act 368

333.21731 Licensee considered consumer of tangible personal property.

Sec. 21731. A licensee of a nursing home operated for profit is considered to be the consumer, and not the retailer, of the tangible personal property purchased and used or consumed in the operation of the home.

History: 1978, Act 368, Eff. Sept. 30, 1978.

Popular name: Act 368

333.21733 Repealed. 2009, Act 188, Eff. May 1, 2010.

Compiler's note: The repealed section pertained to smoking policies in nursing homes.

333.21734 Nursing home; bed rails; provisions; guidelines; liability.

Sec. 21734. (1) Notwithstanding section 20201(2)(I), a nursing home shall give each resident who uses a hospital-type bed or the resident's legal guardian, patient advocate, or other legal representative the option of having bed rails. A nursing home shall offer the option to new residents upon admission and to other residents upon request. Upon receipt of a request for bed rails, the nursing home shall inform the resident or the resident's legal guardian, patient advocate, or other legal representative of alternatives to and the risks involved in using bed rails. A resident or the resident's legal guardian, patient advocate, or other legal representative has the right to request and consent to bed rails for the resident. A nursing home shall provide bed rails to a resident only upon receipt of a signed consent form authorizing bed rail use and a written order from the resident's attending physician that contains statements and determinations regarding medical symptoms and that specifies the circumstances under which bed rails are to be used. For purposes of this subsection, "medical symptoms" includes the following:

(a) A concern for the physical safety of the resident.

(b) Physical or psychological need expressed by a resident. A resident's fear of falling may be the basis of a medical symptom.

(2) A nursing home that provides bed rails under subsection (1) shall do all of the following:

(a) Document that the requirements of subsection (1) have been met.

(b) Monitor the resident's use of the bed rails.

(c) In consultation with the resident, resident's family, resident's attending physician, and individual who consented to the bed rails, periodically reevaluate the resident's need for the bed rails.

(3) The department of consumer and industry services shall develop clear and uniform guidelines to be used in determining what constitutes each of the following:

(a) Acceptable bed rails for use in a nursing home in this state. The department shall consider the

recommendations of the hospital bed safety work group established by the United States food and drug administration, if those are available, in determining what constitutes an acceptable bed rail.

(b) Proper maintenance of bed rails.

(c) Properly fitted mattresses.

(d) Other hazards created by improperly positioned bed rails, mattresses, or beds.

(4) The department of consumer and industry services shall develop the guidelines under subsection (3) in consultation with the long-term care work group. An individual representing manufacturers of bed rails, 2 residents or family members, and an individual with expertise in bed rail installation and use shall be added to the long-term care work group for purposes of this subsection. The department shall consider as part of its report to the legislature the recommendations of the hospital bed safety work group established by the United States food and drug administration, if those recommendations are available at the time of the submission of the report. Not later than 6 months after the effective date of the amendatory act that added this section, the department of consumer and industry services shall submit its report to the legislature. The department may delay submission of its report by up to 3 months so that its report may reflect the recommendations of the hospital bed safety work group established by the United States food and drug administration.

(5) A nursing home that complies with subsections (1) and (2) and the guidelines developed under this section in providing bed rails to a resident is not subject to administrative penalties imposed by the department based solely on providing the bed rails. Nothing in this subsection precludes the department from citing specific state or federal deficiencies for improperly maintained bed rails, improperly fitted mattresses, or other hazards created by improperly positioned bed rails, mattresses, or beds.

(6) The department of consumer and industry services shall consult with representatives of the nursing home industry to expeditiously develop interim guidelines on bed rail usage that are to be used until the department develops the guidelines required under subsection (4).

History: Add. 2000, Act 437, Imd. Eff. Jan. 9, 2001.

Popular name: Act 368

333.21735 Requirement of emergency generator system in nursing home.

Sec. 21735. (1) A nursing home licensed under this article shall have, at a minimum, an emergency generator system that complies with existing state and federal law, including state and federal rules and regulations.

(2) A nursing home that fails to comply with this section is subject to a civil penalty as provided under existing state and federal law, including state and federal rules and regulations.

History: Add. 2004, Act 397, Eff. Apr. 15, 2005.

Popular name: Act 368

333.21741 Rules.

Sec. 21741. (1) The department of public health, after seeking advice and consultation from the department of social services, appropriate consumer and professional organizations, and concerned agencies, shall promulgate rules to implement and administer this part.

(2) Initial rules proposed under this part shall be submitted to a public hearing not later than 6 months after this section is enacted into law.

(3) In addition to the rules prescribed in section 20171, rules for nursing homes shall include the establishment of standards relating to:

(a) Complaint procedures.

(b) Discharges and transfers.

(c) Emergency procedures.

(d) Medical audit procedures.

(e) Patients' rights.

(f) Standards of patient care to be provided in nursing homes.

(g) Training, educational, and competency requirements of nursing home personnel other than licensed personnel.

(h) Utilization and quality control review procedures.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21743 Disclosures; public inspection.

Sec. 21743. (1) In addition to public records subject to disclosure under section 20175, the following information is subject to disclosure from the department of public health or the department of social services:

(a) Ownership of nursing homes, ownership of buildings occupied by nursing homes, and the names and addresses of suppliers and the ownership of suppliers of goods and services to nursing homes required to be reported under section 20142.

(b) Records of license and certification inspections, surveys, and evaluations of nursing homes, other reports of inspections, surveys, and evaluations of patient care, and reports concerning a nursing home prepared pursuant to titles 18 and 19 of the social security act, 42 U.S.C. 1395 to 1396k.

(c) Cost and reimbursement reports submitted by a nursing home, reports of audits of nursing homes, and other public records concerning costs incurred by, revenues received by, and reimbursement of nursing homes.

(d) Complaints filed against a nursing home and complaint investigation reports. A complaint or complaint investigation report shall not be disclosed to a person other than the complainant or complainant's representative before it is disclosed to a nursing home under section 21799a and a complainant's or patient's name shall not be disclosed except as provided in section 21799a.

(2) The department of public health, the department of social services and the nursing home shall respect the confidentiality of a patient's clinical record as provided in section 20175 and shall not divulge or disclose the contents of a record in a manner which identifies a patient, except upon a patient's death to a relative or guardian, or under judicial proceedings. This subsection shall not be construed to limit the right of a patient or a patient's representative to inspect or copy the patient's clinical record.

(3) Confidential medical, social, personal, or financial information identifying a patient shall not be available for public inspection in a manner which identifies a patient.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21744 Professional advice and consultation.

Sec. 21744. The department shall provide to the applicant or licensee professional advice and consultation related to the quality of institutional or agency aspects of health care and services provided by the applicant or licensee.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21751 Emergency petition to place nursing home under control of receiver; appointment of receiver; use of income and assets; major structural alteration; consultation; termination of receivership; accounting; disposition of surplus funds.

Sec. 21751. (1) When the department has concluded a proceeding under sections 71 to 106 of the administrative procedures act of 1969, as amended, being sections 24.271 to 24.306 of the Michigan Compiled Laws, or when the department has suspended or revoked the license of a nursing home, the department, a patient in the facility, or a patient's representative may file an emergency petition with the circuit court to place the nursing home under the control of a receiver if necessary to protect the health or safety of patients in the nursing home. The court may grant the petition upon a finding that the health or safety of the patients in the nursing home would be seriously threatened if a condition existing at the time the petition was filed is permitted to continue.

(2) The court shall appoint as receiver the director of the department of social services, the director of the department of public health, or another state agency or person designated by the director of public health. The receiver appointed by the court shall use the income and assets of the nursing home to maintain and operate the home and to attempt to correct the conditions which constitute a threat to the patients. A major structural alteration shall not be made to the nursing home, unless the alteration is necessary to bring the nursing home into compliance with licensing requirements.

(3) To assist in the implementation of the mandate of the court, the receiver may request and receive reasonable consultation from the available personnel of the department.

(4) The receivership shall be terminated when the receiver and the court certify that the conditions which prompted the appointment have been corrected, when the license is restored, when a new license is issued, or, in the case of a discontinuance of operation, when the patients are safely placed in other facilities, whichever occurs first.

(5) Upon the termination of the receivership, the receiver shall render a complete accounting to the court and shall dispose of surplus funds as the court directs.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21755 Grounds for refusal to issue license.

Sec. 21755. The department may refuse to issue a license to establish or maintain and operate, or both, a nursing home to an applicant:

(a) Whose occupational, professional, or health agency license has been revoked during the 5 years preceding the date of application.

(b) Whom the department finds is not suitable to operate a nursing home because of financial incapacity or a lack of good moral character or appropriate business or professional experience. As used in this subdivision, “good moral character” means that term as defined in Act No. 381 of the Public Acts of 1974, as amended, being sections 338.41 to 338.47 of the Michigan Compiled Laws.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21757 Provisional license.

Sec. 21757. (1) The department may issue a 1-year provisional license, renewable for not more than 1 additional year, to an applicant whose services are needed in the community but who is temporarily unable to comply with the rules related to the physical plant of the facilities, excluding maintenance problems. At the time a provisional license is granted, specific deadlines for the correction of each physical plant violation shall be established.

(2) A provisional license shall not be issued for a nursing home constructed, established, or changing corporate ownership or management after the effective date of this section unless it is shown that unusual hardship would result to the public or to the applicant for the provisional license and the nursing home was licensed and operating under a prior licensing act for not less than 5 years.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21761 Certification of nondiscrimination; violation of rights; giving preference to members of religious or fraternal institution or organization.

Sec. 21761. (1) In addition to the requirements of section 20152, a licensee shall certify annually to the department, as part of its application for licensure and certification, that all phases of its operation, including its training program, are without discrimination against persons or groups of persons on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or the exercise of rights guaranteed by law, including freedom of speech and association. If the department finds a violation of rights enumerated in this section, the department shall direct the administrator of the nursing home to take the necessary action to assure that the nursing home is, in fact, operated in accordance with the rights listed in this section.

(2) This section shall not be construed to prevent a nursing home operated, supervised, or controlled by a religious or fraternal institution or organization from giving preference to applicants who are members of that religious or fraternal institution or organization.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1998, Act 88, Imd. Eff. May 13, 1998.

Popular name: Act 368

333.21763 Access to nursing home patients; purposes; requirements; termination of visit; confidentiality; complaint; determination; prohibited entry.

Sec. 21763. (1) A nursing home shall permit a representative of an approved organization, who is known by the nursing home administration to be authorized to represent the organization or who carries identification showing that the representative is authorized to represent the organization, a family member of a patient, or a legal representative of a patient, to have access to nursing home patients for 1 or more of the following purposes:

(a) Visit, talk with, and make personal, social, and legal services available to the patients.

(b) Inform patients of their rights and entitlements, and their corresponding obligations, under federal and state laws by means of the distribution of educational materials and discussion in groups and with individual patients.

(c) Assist patients in asserting their legal rights regarding claims for public assistance, medical assistance, and social services benefits, as well as in all matters in which patients are aggrieved. Assistance may be provided individually or on a group basis and may include organizational activity and counseling and litigation.

(d) Engage in other methods of assisting, advising, and representing patients so as to extend to them the

full enjoyment of their rights.

(2) Access as prescribed in subsection (1) shall be permitted during regular visiting hours each day. A representative of an approved organization entering a nursing home under this section promptly shall advise the nursing home administrator or the acting administrator or other available agent of the nursing home of the representative's presence. A representative shall not enter the living area of a patient without identifying himself or herself to the patient and without receiving the patient's permission to enter. A representative shall use only patient areas of the home to carry out the activities described in subsection (1).

(3) A patient may terminate a visit by a representative permitted access under subsection (1). Communications between a patient and the representative are confidential, unless otherwise authorized by the patient.

(4) If a nursing home administrator or employee believes that an individual or organization permitted access under this section is acting or has acted in a manner detrimental to the health or safety of patients in the nursing home, the nursing home administrator or employee may file a complaint with the task force established under section 20127. Upon receipt of a complaint, department staff shall investigate the allegations made in the complaint. The task force shall make a determination regarding proper resolution of the complaint based on the results of the investigation. Written notification of the task force determination and of recommendations adopted by the task force shall be given to the complainant and the individual or organization against whom the complaint was made.

(5) An individual shall not enter upon the premises of a nursing home for the purpose of engaging in an activity that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested and that actually causes a nursing home employee, patient, or visitor to feel terrorized, frightened, intimidated, threatened, harassed, or molested. This subsection does not prohibit constitutionally protected activity or conduct that serves a legitimate purpose including, but not limited to, activities or conduct allowed under subsection (1).

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1996, Act 546, Eff. Mar. 31, 1997.

Popular name: Act 368

333.21764 Approval or disapproval of nonprofit corporation rendering assistance without charge; appeal; decision.

Sec. 21764. (1) The director, with the advice of the nursing home task force, shall approve or disapprove a nonprofit corporation which has as 1 of its primary purposes the rendering of assistance, without charge to nursing home patients for the purpose of obtaining access to nursing homes and their patients under section 21763.

(2) Upon receipt of a written application for approval under subsection (1), the director shall notify all persons who have made a written request for notice of applications made under this section.

(3) The director shall approve the organization making the request if the organization is a bona fide community organization or legal aid program, is capable of providing 1 or more of the services listed in section 21763, and is likely to utilize the access provided under section 21763 to enhance the welfare of nursing home patients. The director shall approve or disapprove the organization within 30 days after receiving the application.

(4) A person aggrieved by the decision of the director may appeal the decision to the nursing home task force. A decision of the task force shall be binding on the director.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21765 Policies and procedures; copy of rights enumerated in MCL 333.20201; reading or explaining rights; staff observance of rights, policies, and procedures.

Sec. 21765. (1) A nursing home shall establish written policies and procedures to implement the rights protected under section 20201. The policies shall include a procedure for the investigation and resolution of patient complaints. The policies and procedures shall be subject to approval by the department. The policies and procedures shall be clear and unambiguous, shall be printed in not less than 12-point type, shall be available for inspection by any person, shall be distributed to each patient and representative, and shall be available for public inspection.

(2) Each patient shall be given a copy of the rights enumerated in section 20201 at the time of admission to a nursing home. A patient of a nursing home at the time of the implementation of this section shall be given a copy of the rights enumerated in section 20201 as specified by rule.

(3) A copy shall be given to a person who executes a contract pursuant to section 21766 and to any other person who requests a copy.

(4) If a patient is unable to read the form, it shall be read to the patient in a language the patient understands. In the case of a mentally retarded individual, the rights shall be explained in a manner which that person is able to understand and the explanation witnessed by a third person. In the case of a minor or a person having a legal guardian, both the patient and the parent or legal guardian shall be fully informed of the policies and procedures.

(5) A nursing home shall ensure that its staff is familiar with and observes the rights enumerated in section 20201 and the policies and procedures established under this section.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21765a Certain admission conditions prohibited; enforcement of contract provisions or agreements in conflict with subsections (1) and (2).

Sec. 21765a. (1) A nursing home shall not require an applicant, as a condition of admission, to waive his or her right to benefits under medicare or medicaid, to give oral or written assurance that the applicant is not eligible for medicare or medicaid, or to give oral or written assurance that the applicant will not apply for benefits under medicare or medicaid.

(2) A nursing home shall not require any of the following as a condition of an applicant's admission or a patient's continued residency at that nursing home:

(a) That an applicant or patient remain a private pay patient for a specified period of time before applying for medicaid.

(b) That a person pay on behalf of an applicant or patient the private pay rate for a specified period of time before the applicant or patient applies for medicaid.

(c) That an applicant, patient, or other person make a gift or donation on behalf of that applicant or patient.

(3) As of the effective date of this section, a contract provision or agreement in conflict with subsection (1) or (2), whether made before, on, or after the effective date of this section, is unenforceable.

(4) Not later than 30 days after the effective date of this section, a nursing home that participates in medicaid shall provide written notice to each private pay patient subject to a contract provision or agreement in conflict with subsection (1) or (2) that the contract provision or agreement is no longer a bar to the patient applying for medicaid.

History: Add. 1994, Act 73, Imd. Eff. Apr. 11, 1994.

Popular name: Act 368

333.21766 Written contract.

Sec. 21766. (1) A nursing home shall execute a written contract solely with an applicant or patient or that applicant's or patient's guardian or legal representative authorized by law to have access to those portions of the patient's or applicant's income or assets available to pay for nursing home care, at each of the following times:

(a) At the time an individual is admitted to a nursing home.

(b) At the expiration of the term of a previous contract.

(c) At the time the source of payment for the patient's care changes.

(2) A nursing home shall not discharge or transfer a patient at the expiration of the term of a contract, except as provided in section 21773.

(3) A nursing home shall specifically notify in writing an applicant or patient or that applicant's or patient's guardian or legal representative of the availability or lack of availability of hospice care in the nursing home. This written notice shall be by way of a specific paragraph located in the written contract described in subsection (1) and shall require the applicant or patient or that applicant's or patient's guardian or legal representative to sign or initial the paragraph before execution of the written contract. As used in this subsection, "hospice" means that term as defined in section 20106(4).

(4) A nursing home shall provide a copy of the contract to the patient, the patient's representative, or the patient's legal representative or legal guardian at the time the contract is executed.

(5) For a patient supported by funds other than the patient's own funds, a nursing home shall make a copy of the contract available to the person providing the funds for the patient's support.

(6) For a patient whose care is reimbursed with public funds administered by the department of community health, a nursing home shall maintain a copy of the contract in the patient's file at the nursing home and upon request shall make a copy of the contract available to the department of community health.

(7) The nursing home shall ensure that the contract is written in clear and unambiguous language and is printed in not less than 12-point type. The form of the contract shall be prescribed by the department.

(8) The contract shall specify all of the following:

- (a) The term of the contract.
- (b) The services to be provided under the contract, including the availability of hospice or other special care, and the charges for the services.
- (c) The services that may be provided to supplement the contract and the charges for the services.
- (d) The sources liable for payments due under the contract.
- (e) The amount of deposit paid and the general and foreseeable terms upon which the deposit will be held and refunded.
- (f) The rights, duties, and obligations of the patient, except that the specification of a patient's rights may be furnished on a separate document that complies with the requirements of section 20201.
- (9) The nursing home may require a patient's or applicant's guardian or legal representative who is authorized by law to have access to those portions of the patient's or applicant's income or assets available to pay for nursing home care to sign a contract without incurring personal financial liability other than for funds received in his or her legal capacity on behalf of the patient.
- (10) A nursing home employee may request the appointment of a guardian for an individual applicant or patient only if the nursing home employee reasonably believes that the individual meets the legal requirements for the appointment of a guardian.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1994, Act 73, Imd. Eff. Apr. 11, 1994;—Am. 2001, Act 243, Eff. July 1, 2002.

Popular name: Act 368

333.21767 Guardian, trustee, conservator, patient's representative, or protective payee for patient; receipt for money or property of patient; statement of funds.

Sec. 21767. (1) A nursing home, or an owner, administrator, employee, or representative of a nursing home shall not act as guardian, trustee, conservator, patient's representative, or protective payee for a patient, except as provided in subsection (2).

(2) Subject to the bonding requirements of section 21721, money or other property belonging or due a patient which is received by a nursing home shall be received as trust funds or property, shall be kept separate from the funds and property of the nursing home and other patients, and shall be disbursed only as directed by the patient. A written receipt shall be given to a patient whose money or other property is received by a nursing home. Upon request, but not less than once every 3 months, the nursing home shall furnish the patient a complete and verified statement of the funds or other property received by the nursing home. The statement shall contain the amounts and items received, the sources, the disposition, and the date of each transaction. The nursing home shall furnish a final statement not later than 10 days after the discharge of a patient.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21771 Abusing, mistreating, or neglecting patient; reports; investigation; retaliation prohibited; exception to report requirement; time frame for reporting.

Sec. 21771. (1) A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a patient.

(2) A nursing home employee who has reasonable suspicion of an act prohibited by this section shall report the suspicion to the nursing home administrator or nursing director and to the department in the manner required by subsection (8). A nursing home administrator or nursing director who has reasonable suspicion of an act prohibited by this section shall report the suspicion by telephone to the department and 1 or more law enforcement entities in the manner required by subsection (8).

(3) Any individual may report a violation of this section to the department.

(4) A physician or other licensed health care personnel of a hospital or other health care facility to which a patient is transferred who has reasonable suspicion of an act prohibited by this section shall report the suspicion to the department and 1 or more law enforcement entities in the manner required by subsection (8).

(5) Upon receipt of a report made under this section, the department shall make an investigation. The department may require the individual making the report to submit a written report or to supply additional information, or both.

(6) A nursing home employee, licensee, or nursing home administrator shall not evict, harass, dismiss, or retaliate against a patient, a patient's representative, or an employee who makes a report under this section.

(7) An individual required to report an act or a reasonable suspicion under subsections (2) to (4) is not required to report the act or suspicion to the department or 1 or more local law enforcement entities if the individual knows that another individual has already reported the act or suspicion as required by this section.

(8) An individual required to report a reasonable suspicion of an act prohibited by this section shall report

the suspicion as follows:

(a) If the act that causes the suspicion results in serious bodily injury to the patient, the individual shall report the suspicion immediately, but not more than 2 hours after forming the suspicion.

(b) If the act that causes the suspicion does not result in serious bodily injury to the patient, the individual shall report the suspicion not more than 24 hours after forming the suspicion.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2012, Act 174, Imd. Eff. June 19, 2012.

Popular name: Act 368

333.21772 Interference with right to bring action or file complaint prohibited; retaliation prohibited.

Sec. 21772. The owner, administrator, employee, or representative of a nursing home shall not interfere with the right of a person to bring a civil or criminal action or to file a complaint with the department or other governmental agency with respect to the operation of the nursing home, nor discharge, harass, or retaliate against a person who does so or on whose behalf the action is taken.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21773 Involuntary transfer or discharge of patient; notice; form; request for hearing; copy of notice; commencement of notice period; nonpayment; redemption; explanation and discussion; counseling services; prohibition; notice of nonparticipation in state plan for medicaid funding.

Sec. 21773. (1) A nursing home shall not involuntarily transfer or discharge a patient except for 1 or more of the following purposes:

- (a) Medical reasons.
- (b) The patient's welfare.
- (c) The welfare of other patients or nursing home employees.

(d) Nonpayment for the patient's stay, except as prohibited by title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

(2) A licensed nursing home shall provide written notice at least 30 days before a patient is involuntarily transferred or discharged. The 30-day requirement of this subsection does not apply in any of the following instances:

(a) If an emergency transfer or discharge is mandated by the patient's health care needs and is in accord with the written orders and medical justification of the attending physician.

(b) If the transfer or discharge is mandated by the physical safety of other patients and nursing home employees as documented in the clinical record.

(c) If the transfer or discharge is subsequently agreed to by the patient or the patient's legal guardian, and notification is given to the next of kin and the person or agency responsible for the patient's placement, maintenance, and care in the nursing home.

(3) The notice required by subsection (2) shall be on a form prescribed by the department of consumer and industry services and shall contain all of the following:

- (a) The stated reason for the proposed transfer.
- (b) The effective date of the proposed transfer.

(c) A statement in not less than 12-point type that reads: "You have a right to appeal the nursing home's decision to transfer you. If you think you should not have to leave this facility, you may file a request for a hearing with the department of consumer and industry services within 10 days after receiving this notice. If you request a hearing, it will be held at least 7 days after your request, and you will not be transferred during that time. If you lose the hearing, you will not be transferred until at least 30 days after you received the original notice of the discharge or transfer. A form to appeal the nursing home's decision and to request a hearing is attached. If you have any questions, call the department of consumer and industry services at the number listed below."

(d) A hearing request form, together with a postage paid, preaddressed envelope to the department of consumer and industry services.

(e) The name, address, and telephone number of the responsible official in the department of consumer and industry services.

(4) A request for a hearing made under subsection (3) shall stay a transfer pending a hearing or appeal decision.

(5) A copy of the notice required by subsection (3) shall be placed in the patient's clinical record and a

copy shall be transmitted to the department of consumer and industry services, the patient, the patient's next of kin, patient's representative, or legal guardian, and the person or agency responsible for the patient's placement, maintenance, and care in the nursing home.

(6) If the basis for an involuntary transfer or discharge is the result of a negative action by the department of community health with respect to a medicaid client and a hearing request is filed with that department, the 21-day written notice period of subsection (2) does not begin until a final decision in the matter is rendered by the department of community health or a court of competent jurisdiction and notice of that final decision is received by the patient and the nursing home.

(7) If nonpayment is the basis for involuntary transfer or discharge, the patient may redeem up to the date that the discharge or transfer is to be made and then may remain in the nursing home.

(8) The nursing home administrator or other appropriate nursing home employee designated by the nursing home administrator shall discuss an involuntary transfer or discharge with the patient, the patient's next of kin or legal guardian, and person or agency responsible for the patient's placement, maintenance, and care in the nursing home. The discussion shall include an explanation of the reason for the involuntary transfer or discharge. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the patient's clinical record.

(9) The nursing home shall provide the patient with counseling services before the involuntary transfer or discharge and the department shall assure that counseling services are available after the involuntary transfer or discharge to minimize the possible adverse effect of the involuntary transfer or discharge.

(10) If a nursing home voluntarily withdraws from participation in the state plan for medicaid funding, but continues to provide services, the nursing home shall not, except as provided in subsection (1), involuntarily transfer or discharge a patient, whether or not the patient is eligible for medicaid benefits, who resided in the nursing home on the day before the effective date of the nursing home's withdrawal from participation. The prohibition against transfer or discharge imposed by this subsection continues unless the patient falls within 1 or more of the exceptions described in subsection (1).

(11) If an individual becomes a patient of a nursing home after the date the nursing home withdraws from participation in the state plan for medicaid funding, the nursing home, on or before the date the individual signs a contract with the nursing home, shall provide to the patient oral and written notice of both of the following:

(a) That the nursing home is not participating in the state plan for medicaid funding.

(b) That the facility may involuntarily transfer or discharge the patient for nonpayment under subsection (1)(d) even if the patient is eligible for medicaid benefits.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2001, Act 137, Imd. Eff. Oct. 26, 2001.

Popular name: Act 368

333.21774 Involuntary transfer or discharge; request for hearing; informal hearing; decision; burden of proof; procedures; time for leaving facility.

Sec. 21774. (1) A patient subject to involuntary transfer or discharge from a licensed nursing home shall have the opportunity to file a request for a hearing with the department within 10 days following receipt of the written notice of the involuntary transfer or discharge by the nursing home.

(2) The department of public health, when the basis for involuntary transfer or discharge is other than a negative action by the department of social services with respect to a medicaid client, shall hold an informal hearing in the matter at the patient's facility not sooner than 7 days after a hearing request is filed, and render a decision in the matter within 14 days after the filing of the hearing request.

(3) In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge. The hearing shall be in accordance with fair hearing procedures prescribed by rule.

(4) If the department determines that a transfer or discharge is authorized under section 21773, the patient shall not be required to leave the facility before the thirty-fourth day following receipt of the notice required under section 21773(2), or the tenth day following receipt of the department's decision, whichever is later.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21775 Continuation of medicaid funding during appeal, transfer, or discharge period.

Sec. 21775. The department of social services shall continue medicaid funding during the appeal, transfer, or discharge period as provided in section 21774 for those medicaid patients affected by section 21773.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1994, Act 73, Imd. Eff. Apr. 11, 1994.

Popular name: Act 368

333.21776 Transfer or discharge of patient; plan; counseling services.

Sec. 21776. The licensee, with the approval of the department, shall develop a plan to effectuate the orderly and safe transfer or discharge of a patient. The patient and the patient's family or representative shall be consulted in choosing another facility. The patient shall receive counseling services before the move to minimize the adverse effects of transfer trauma. The department shall assure that counseling will be available if the patient requires counseling after transfer or discharge.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21777 Holding bed open during temporary absence of patient; option; title 19 patients.

Sec. 21777. (1) If a patient is temporarily absent from a nursing home for emergency medical treatment, the nursing home shall hold the bed open for 10 days for that patient in the patient's absence, if there is a reasonable expectation that the patient will return within that period of time and the nursing home receives payment for each day during the absent period.

(2) If a patient is temporarily absent from a nursing home for therapeutic reasons as approved by a physician, the nursing home shall hold the bed open for 18 days, if there is a reasonable expectation that the patient will return within that period of time and the nursing home receives payment for each day during the absent period. Temporary absences for therapeutic reasons are limited to 18 days per year.

(3) When a patient's absence is longer than specified under subsection (1) or (2), or both, the patient has the option to return to the nursing home for the next available bed.

(4) For title 19 patients, the department of community health shall continue funding for the temporary absence as provided under subsections (1) and (2) if the nursing home is at 98% or more occupancy except for any bed being held open under subsection (1) or (2).

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2004, Act 372, Imd. Eff. Oct. 11, 2004.

Popular name: Act 368

333.21781 Posting of license and other information.

Sec. 21781. A licensee shall conspicuously post in an area of its offices accessible to patients, employees, and visitors:

(a) A current license.

(b) A complete copy of the most recent inspection report of the nursing home received from the department.

(c) A description, provided by the department, of complaint procedures established under this act and the name, address, and telephone number of a person authorized by the department to receive complaints.

(d) A copy of a notice of a pending hearing or order pertaining to the nursing home issued by the department or a court under the authority of this article or rules promulgated under this article.

(e) A complete list of materials available for public inspection as required by section 21782.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21782 Retention of documents for public inspection.

Sec. 21782. A licensee shall retain for public inspection:

(a) A complete copy of each inspection report of the nursing home received from the department during the past 5 years.

(b) A copy of each notice of a hearing or order pertaining to the nursing home issued by the department or a court under the authority of this article or rules promulgated under this article after the effective date of this section. The copy of the notice or order shall be retained for not less than 3 years after its date of issuance or not less than 3 years after the date of the resolution of the subject matter of the notice or order, whichever is later.

(c) A description of the services provided by the nursing home and the rates charged for those services and items for which a patient may be separately charged.

(d) A list of the name, address, principal occupation, and official position of each person who, as a stockholder or otherwise, has a proprietary interest in the nursing home as required by section 20142, of each officer and director of a nursing home which is a corporation, and of each trustee or beneficiary of a nursing home which is a trust.

(e) A list of licensed personnel employed or retained by the nursing home.

(f) A copy of the standard form contract utilized under section 21766.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21784 Threatening medical condition; notice; emergency treatment; comfort of patient.

Sec. 21784. If a patient's life is threatened by his or her medical condition, the nursing home shall immediately notify the patient's next of kin, patient's representative, and physician. The nursing home shall secure emergency medical treatment for the patient when the patient's physician is not available. A nursing home shall take all reasonable measures to ensure the comfort of a patient in the terminal stages of an illness.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21785 Discontinuance of operation; notice; relocation of patients.

Sec. 21785. (1) If a nursing home proposes to discontinue operation, the licensee shall notify the department of public health and the department of social services of the impending discontinuance of operation. The licensee shall notify the patient and the patient's next of kin, patient's representative, and the party executing the contract under section 21766 of the proposed date of the discontinuance. The notice shall be sufficient to make suitable arrangements for the transfer and care of the patient.

(2) The notices required by this section shall be given not less than 30 days before the discontinuance.

(3) The licensee and the department of social services shall be responsible for securing a suitable relocation of a patient who does not have a relative or legal representative to assist in his or her relocation before the discontinuance of operation. The licensee and the department of social services shall keep the department of public health informed of their efforts and activities in carrying out this responsibility. The department of social services shall make available to the licensee and the department of public health assistance necessary to assure the effectiveness of efforts to secure a suitable relocation.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21786 Emergency closing of nursing home.

Sec. 21786. In the case of an emergency closing of a nursing home, or when it is determined by the department that a nursing home is suddenly no longer able to provide adequate patient care, the department shall do both of the following:

(a) Assure that the department of social services has been notified to make arrangements for the orderly and safe discharge and transfer of the patients to another facility.

(b) Place a representative of the department in a facility on a daily basis to do each of the following:

(i) Monitor the discharge of patients to other facilities or locations.

(ii) Ensure that the rights of patients are protected.

(iii) Discuss the discharge and relocation with each patient and next of kin or legal guardian, person, or agency responsible for the patient's placement, maintenance, and care in the facility. The content of the explanation and discussion shall be summarized in writing and shall be made a part of the patient's clinical record.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21787 Michigan public health institute; consultation and contracts.

Sec. 21787. The department may consult and work with the Michigan public health institute created under section 2611 in performing the department's regulatory and disciplinary duties under this article. The department may also contract with the Michigan public health institute for the performance of specific functions required or authorized by this article, if determined necessary by the director of the department.

History: Add. 2000, Act 501, Imd. Eff. Jan. 11, 2001.

Popular name: Act 368

333.21791 Advertising; false or misleading information prohibited.

Sec. 21791. A licensee shall not use false or misleading information in the advertising of a nursing home or its name.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21792 Commission, bonus, fee, or gratuity; violation; penalty.

Sec. 21792. (1) An owner, administrator, employee, or representative of a nursing home shall not pay, or offer to pay, a commission, bonus, fee, or gratuity to a physician, surgeon, organization, agency, or other person for the referral of a patient to a nursing home.

(2) A person shall not offer or give a commission, bonus, fee, or gratuity to an owner, administrator, employee, or representative of a nursing home in return for the purchase of a drug, biological, or any other ancillary services provided for a patient of a nursing home.

(3) An owner, administrator, employee, or representative of a nursing home shall not accept a commission, bonus, fee, or gratuity in return for the purchase of a drug, biological, or any other ancillary services provided for a patient of a nursing home.

(4) A person who violates this section is guilty of a felony, punishable by imprisonment for not more than 4 years, or a fine of not more than \$30,000.00, or both.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21795 Education and training for unlicensed nursing personnel; criteria; competency examinations; rules.

Sec. 21795. (1) The department, in consultation and with the advice of the Michigan board of nursing and appropriate consumer and professional organizations, shall develop by rule minimum criteria for the education and training for unlicensed nursing personnel in facilities designated in this part.

(2) This section shall not be construed to be a prerequisite for employment of unlicensed nursing personnel in a nursing home.

(3) During the annual licensing inspection the department shall, and during other inspections the department may, conduct random competency examinations to determine whether the requirements of this section are being met. The department shall promulgate rules to administer this subsection.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21796 Insuring proper licensing of licensed personnel.

Sec. 21796. The nursing home administrator and licensee shall be responsible for insuring that all licensed personnel employed by the nursing home are properly licensed.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21799a Nursing home; violation; complaint; investigation; disclosure; determination; listing violation and provisions violated; copies of documents; public inspection; report of violation; penalty; request for hearing; notice of hearing; "priority complaint" defined.

Sec. 21799a. (1) A person who believes that this part, a rule promulgated under this part, or a federal certification regulation applying to a nursing home may have been violated may request an investigation of a nursing home. The person may submit the request for investigation to the department as a written complaint, or the department shall assist a person in reducing an oral request made under subsection (2) to a written complaint as provided in subsection (2). A person filing a complaint under this subsection may file the complaint on a model standardized complaint form developed and distributed by the department under section 20194(3) or file the complaint as provided by the department on the internet.

(2) The department shall provide a toll-free telephone consumer complaint line. The complaint line shall be accessible 24 hours per day and monitored at a level to ensure that each priority complaint is identified and that a response is initiated to each priority complaint within 24 hours after its receipt. The department shall establish a system for the complaint line that includes at least all of the following:

(a) An intake form that serves as a written complaint for purposes of subsections (1) and (5).

(b) The forwarding of an intake form to an investigator not later than the next business day after the complaint is identified as a priority complaint.

(c) Except for an anonymous complaint, the forwarding of a copy of the completed intake form to the complainant not later than 5 business days after it is completed.

(3) The substance of a complaint filed under subsection (1) or (2) shall be provided to the licensee no earlier than at the commencement of the on-site inspection of the nursing home that takes place in response to the complaint.

(4) A complaint filed under subsection (1) or (2), a copy of the complaint, or a record published, released, or otherwise disclosed to the nursing home shall not disclose the name of the complainant or a patient named

in the complaint unless the complainant or patient consents in writing to the disclosure or the investigation results in an administrative hearing or a judicial proceeding, or unless disclosure is considered essential to the investigation by the department. If the department considers disclosure essential to the investigation, the department shall give the complainant the opportunity to withdraw the complaint before disclosure.

(5) Upon receipt of a complaint under subsection (1) or (2), the department shall determine, based on the allegations presented, whether this part, a rule promulgated under this part, or a federal certification regulation for nursing homes has been, is, or is in danger of being violated. Subject to subsection (2), the department shall investigate the complaint according to the urgency determined by the department. The initiation of a complaint investigation shall commence within 15 days after receipt of the written complaint by the department.

(6) If, at any time, the department determines that this part, a rule promulgated under this part, or a federal certification regulation for nursing homes has been violated, the department shall list the violation and the provisions violated on the state and federal licensure and certification forms for nursing homes. The department shall consider the violations, as evidenced by a written explanation, when it makes a licensure and certification decision or recommendation.

(7) In all cases, the department shall inform the complainant of its findings unless otherwise indicated by the complainant. Subject to subsection (2), within 30 days after receipt of the complaint, the department shall provide the complainant a copy, if any, of the written determination, the correction notice, the warning notice, and the state licensure or federal certification form, or both, on which the violation is listed, or a status report indicating when these documents may be expected. The department shall include in the final report a copy of the original complaint. The complainant may request additional copies of the documents described in this subsection and upon receipt shall reimburse the department for the copies in accordance with established policies and procedures.

(8) The department shall make a written determination, correction notice, or warning notice concerning a complaint available for public inspection, but the department shall not disclose the name of the complainant or patient without the complainant's or patient's consent.

(9) The department shall report a violation discovered as a result of the complaint investigation procedure to persons administering sections 21799c to 21799e. The department shall assess a penalty for a violation, as prescribed by this article.

(10) A complainant who is dissatisfied with the determination or investigation by the department may request a hearing. A complainant shall submit a request for a hearing in writing to the director within 30 days after the mailing of the department's findings as described in subsection (7). The department shall send notice of the time and place of the hearing to the complainant and the nursing home.

(11) As used in this section, "priority complaint" means a complaint alleging an existing situation that involves physical, mental, or emotional abuse, mistreatment, or harmful neglect of a resident that requires immediate corrective action to prevent serious injury, serious harm, serious impairment, or death of a resident while receiving care in a facility.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2003, Act 3, Imd. Eff. Apr. 22, 2003;—Am. 2004, Act 189, Imd. Eff. July 8, 2004.

Popular name: Act 368

333.21799b Noncompliance; notice of finding; correction notices; hearing; verification of compliance; investigation; action; definitions; annual report; presumption.

Sec. 21799b. (1) If, upon investigation, the department of consumer and industry services finds that a licensee is not in compliance with this part, a rule promulgated under this part, or a federal law or regulation governing nursing home certification under title XVIII or XIX, which noncompliance impairs the ability of the licensee to deliver an acceptable level of care and services, or in the case of a nursing home closure, the department of consumer and industry services shall notify the department of community health of the finding and may issue 1 or more of the following correction notices to the licensee:

- (a) Suspend the admission or readmission of patients to the nursing home.
- (b) Reduce the licensed capacity of the nursing home.
- (c) Selectively transfer patients whose care needs are not being met by the licensee.
- (d) Initiate action to place the home in receivership as prescribed in section 21751.

(e) Require appointment at the nursing home's expense of a department approved temporary administrative advisor or a temporary clinical advisor, or both, with authority and duties specified by the department to assist the nursing home management and staff to achieve sustained compliance with required operating standards.

(f) Require appointment at the nursing home's expense of a department approved temporary manager with authority and duties specified by the department to oversee the nursing home's achievement of sustained

compliance with required operating standards or to oversee the orderly closure of the nursing home.

(g) Issue a correction notice to the licensee and the department of community health describing the violation and the statute or rule violated and specifying the corrective action to be taken and the period of time in which the corrective action is to be completed. Upon issuance, the director shall cause to be published in a daily newspaper of general circulation in an area in which the nursing home is located notice of the action taken and the listing of conditions upon which the director's action is predicated.

(2) Within 72 hours after receipt of a notice issued under subsection (1), the licensee shall be given an opportunity for a hearing on the matter. The director's notice shall continue in effect during the pendency of the hearing and any subsequent court proceedings. The hearing shall be conducted in compliance with the administrative procedures act of 1969.

(3) A licensee who believes that a correction notice has been complied with may request a verification of compliance from the department. Not later than 72 hours after the licensee makes the request, the department shall investigate to determine whether the licensee has taken the corrective action prescribed in the notice under subsection (1)(g). If the department finds that the licensee has taken the corrective action and that the conditions giving rise to the notice have been alleviated, the department may cease taking further action against the licensee, or may take other action that the director considers appropriate.

(4) As used in this part, "title XVIII" and "title XIX" mean those terms as defined in section 20155.

(5) The department shall report annually to the house and senate standing committees on senior issues on the number of times the department appointed a temporary administrative advisor, temporary clinical advisor, and temporary manager as described in subsection (1)(e) or (f). The report shall include whether the nursing home closed or remained open. The department may include this report with other reports made to fulfill legislative reporting requirements.

(6) If the department determines that a nursing home's patients can be safeguarded and provided with a safe environment, the department shall make its decisions concerning the nursing home's future operation based on a presumption in favor of keeping the nursing home open.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 2000, Act 437, Imd. Eff. Jan. 9, 2001.

Popular name: Act 368

333.21799c Violations; penalties; computation of civil penalties; paying or reimbursing patient; rules for quality of care allowance formula.

Sec. 21799c. (1) A person who violates 1 of the following sections is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year or a fine of not less than \$1,000.00, nor more than \$10,000.00, or both:

- (a) Section 21711.
- (b) Section 21712.
- (c) Section 21763(5).
- (d) Section 21765a(1) or (2).
- (e) Section 21771(1) or (6).
- (f) Section 21791.

(2) A person who violates section 21765a(1) or (2) is liable to an applicant or patient in a civil action for treble the amount of actual damages or \$1,000.00, whichever is greater, together with costs and reasonable attorney fees.

(3) For the purpose of computing administrative penalties under this section, the number of patients per day is based on the average number of patients in the nursing home during the 30 days immediately preceding the discovery of the violation.

(4) If the department finds a violation of section 20201 as to a particular nursing home patient, the department shall issue an order requiring the nursing home to pay to the patient \$100.00, or to reimburse the patient for costs incurred or injuries sustained as a result of the violation, whichever is greater. The department also shall assess the nursing home an administrative penalty that is the lesser of the following:

- (a) Not more than \$1,500.00.
- (b) \$15.00 per patient bed.

(5) The department of community health shall promulgate rules for a quality of care allowance formula that is consistent with the recommendations of the fiscal incentives subcommittee to the committee on nursing home reimbursement established pursuant to Act No. 241 of the Public Acts of 1975, as described in the November 24, 1975 interim report, in the December 3, 1975 final report, and the November 24, 1976 report of the committee recommending appropriate changes in the procedures utilized.

(6) The department shall not assess an administrative penalty under subsection (4) for a violation of this part for which a nursing home's reimbursement is withheld under subsection (5).

History: Add. 1978, Act 493, Eff. Mar. 30, 1979;—Am. 1994, Act 73, Imd. Eff. Apr. 11, 1994;—Am. 1996, Act 546, Eff. Mar. 31, 1997.

Popular name: Act 368

333.21799d Collection of civil penalty; noncompliance; order.

Sec. 21799d. A civil penalty assessed under this part shall be collected by the department. If the person or nursing home against whom a civil penalty has been assessed does not comply with a written demand for payment within 30 days, the department shall issue an order to do 1 of the following:

(a) Direct the department of treasury to deduct the amount of the civil penalty from amounts otherwise due from the state to the nursing home and remit that amount to the department.

(b) Add the amount of the civil penalty to the nursing home's licensing fee. If the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed.

(c) Bring an action in circuit court to recover the amount of the civil penalty.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

333.21799e Penalties and remedies cumulative.

Sec. 21799e. (1) The penalties prescribed by this part or a rule promulgated under this part are cumulative and not exclusive. Neither the department nor any other party is limited to the remedies in this part.

(2) The remedies provided under section 20155 and sections 21799a to 21799d are independent and cumulative. Except as provided in section 21799(c)(5), the use of 1 remedy by a person shall not be considered a bar to the use of other remedies by that person or to the use of any remedy by another person.

History: Add. 1978, Act 493, Eff. Mar. 30, 1979.

Popular name: Act 368

PART 221 CERTIFICATES OF NEED

333.22101-333.22181 Repealed. 1981, Act 76, Eff. Oct. 1, 1981;—1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22190 Expired. 1979, Act 113, Eff. Dec. 31, 1979.

Popular name: Act 368

PART 222 CERTIFICATES OF NEED

333.22201 Meanings of words and phrases; principles of construction.

Sec. 22201. (1) For purposes of this part, the words and phrases defined in sections 22203 to 22207 have the meanings ascribed to them in those sections.

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

(3) The definitions in part 201 do not apply to this part.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Compiler's note: For transfer of certain powers and duties of the division of health facility development in the bureau of health systems from the department of public health to the director of the department of community health, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

Popular name: Act 368

333.22203 Definitions; A to F.

Sec. 22203. (1) "Addition" means adding patient rooms, beds, and ancillary service areas, including, but not limited to, procedure rooms or fixed equipment, surgical operating rooms, therapy rooms or fixed equipment, or other accommodations to a health facility.

(2) "Capital expenditure" means an expenditure for a single project, including cost of construction, engineering, and equipment that under generally accepted accounting principles is not properly chargeable as an expense of operation. Capital expenditure includes a lease or comparable arrangement by or on behalf of a health facility to obtain a health facility, licensed part of a health facility, or equipment for a health facility, if the actual purchase of a health facility, licensed part of a health facility, or equipment for a health facility

would have been considered a capital expenditure under this part. Capital expenditure includes the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of physical plant and equipment.

(3) "Certificate of need" means a certificate issued under this part authorizing a new health facility, a change in bed capacity, the initiation, replacement, or expansion of a covered clinical service, or a covered capital expenditure that is issued in accordance with this part.

(4) "Certificate of need review standard" or "review standard" means a standard approved by the commission.

(5) "Change in bed capacity" means 1 or more of the following:

(a) An increase in licensed hospital beds.

(b) An increase in licensed nursing home beds or hospital beds certified for long-term care.

(c) An increase in licensed psychiatric beds.

(d) A change from 1 licensed use to a different licensed use.

(e) The physical relocation of beds from a licensed site to another geographic location.

(6) "Clinical" means directly pertaining to the diagnosis, treatment, or rehabilitation of an individual.

(7) "Clinical service area" means an area of a health facility, including related corridors, equipment rooms, ancillary service and support areas that house medical equipment, patient rooms, patient beds, diagnostic, operating, therapy, or treatment rooms or other accommodations related to the diagnosis, treatment, or rehabilitation of individuals receiving services from the health facility.

(8) "Commission" means the certificate of need commission created under section 22211.

(9) "Covered capital expenditure" means a capital expenditure of \$2,500,000.00 or more, as adjusted annually by the department under section 22221(g), by a person for a health facility for a single project, excluding the cost of nonfixed medical equipment, that includes or involves the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of a clinical service area.

(10) "Covered clinical service", except as modified by the commission under section 22215, means 1 or more of the following:

(a) Initiation or expansion of 1 or more of the following services:

(i) Neonatal intensive care services or special newborn nursing services.

(ii) Open heart surgery.

(iii) Extrarenal organ transplantation.

(b) Initiation, replacement, or expansion of 1 or more of the following services:

(i) Extracorporeal shock wave lithotripsy.

(ii) Megavoltage radiation therapy.

(iii) Positron emission tomography.

(iv) Surgical services provided in a freestanding surgical outpatient facility, an ambulatory surgery center certified under title XVIII, or a surgical department of a hospital licensed under part 215 and offering inpatient or outpatient surgical services.

(v) Cardiac catheterization.

(vi) Fixed and mobile magnetic resonance imager services.

(vii) Fixed and mobile computerized tomography scanner services.

(viii) Air ambulance services.

(c) Initiation or expansion of a specialized psychiatric program for children and adolescent patients utilizing licensed psychiatric beds.

(d) Initiation, replacement, or expansion of a service not listed in this subsection, but designated as a covered clinical service by the commission under section 22215(1)(a).

(11) "Fixed equipment" means equipment that is affixed to and constitutes a structural component of a health facility, including, but not limited to, mechanical or electrical systems, elevators, generators, pumps, boilers, and refrigeration equipment.

History: Add. 1988, Act 331, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22205 Definitions; H to M.

Sec. 22205. (1) "Health facility", except as otherwise provided in subsection (2), means:

(a) A hospital licensed under part 215.

(b) A psychiatric hospital or psychiatric unit licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(c) A nursing home licensed under part 217 or a hospital long-term care unit as defined in section 20106(6).

(d) A freestanding surgical outpatient facility licensed under part 208.

(e) A health maintenance organization issued a license or certificate of authority in this state.

(2) "Health facility" does not include the following:

(a) An institution conducted by and for the adherents of a church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend solely upon spiritual means through prayer for healing.

(b) A health facility or agency located in a correctional institution.

(c) A veterans facility operated by the state or federal government.

(d) A facility owned and operated by the department of community health.

(3) "Initiate" means the offering of a covered clinical service that has not been offered in compliance with this part or former part 221 on a regular basis at that location within the 12-month period immediately preceding the date the covered clinical service will be offered.

(4) "Medical equipment" means a single equipment component or a related system of components that is used for clinical purposes.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2000, Act 253, Imd. Eff. June 29, 2000;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22207 Definitions; M to S.

Sec. 22207. (1) "Medicaid" means the program for medical assistance administered by the department of community health under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(2) "Modernization" means an upgrading, alteration, or change in function of a part or all of the physical plant of a health facility. Modernization includes, but is not limited to, the alteration, repair, remodeling, and renovation of an existing building and initial fixed equipment and the replacement of obsolete fixed equipment in an existing building. Modernization of the physical plant does not include normal maintenance and operational expenses.

(3) "New construction" means construction of a health facility where a health facility does not exist or construction replacing or expanding an existing health facility or a part of an existing health facility.

(4) "Person" means a person as defined in section 1106 or a governmental entity.

(5) "Planning area" means the area defined in a certificate of need review standard for determining the need for, and the resource allocation of, a specific health facility, service, or equipment. Planning area includes, but is not limited to, the state, a health facility service area, or a health service area or subarea within the state.

(6) "Proposed project" means a proposal to acquire an existing health facility or begin operation of a new health facility, make a change in bed capacity, initiate, replace, or expand a covered clinical service, or make a covered capital expenditure.

(7) "Rural county" means a county not located in a metropolitan statistical area or micropolitan statistical areas as those terms are defined under the "standards for defining metropolitan and micropolitan statistical areas" by the statistical policy office of the office of information and regulatory affairs of the United States office of management and budget, 65 F.R. p. 82238 (December 27, 2000).

(8) "Stipulation" means a requirement that is germane to the proposed project and has been agreed to by an applicant as a condition of certificate of need approval.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22208 Definitions; T.

Sec. 22208. (1) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(2) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 USC 1396 to 1396w-5.

History: Add. 1988, Act 308, Eff. Oct. 1, 1988;—Am. 1990, Act 260, Imd. Eff. Oct. 15, 1990;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2011, Act 51, Eff. Dec. 6, 2011.

Popular name: Act 368

333.22209 Activities requiring certificate of need; exceptions; requirements; acquisition of existing health facility; relocation; "sharing agreement" defined.

Sec. 22209. (1) Except as otherwise provided in this part, a person shall not do any of the following without first obtaining a certificate of need:

(a) Acquire an existing health facility or begin operation of a health facility at a site that is not currently licensed for that type of health facility.

(b) Make a change in the bed capacity of a health facility.

(c) Initiate, replace, or expand a covered clinical service.

(d) Make a covered capital expenditure.

(2) A certificate of need is not required for a reduction in licensed bed capacity or services at a licensed site.

(3) Subject to subsection (9) and if the relocation does not result in an increase of licensed beds within that health service area, a certificate of need is not required for any of the following:

(a) The physical relocation of licensed beds from a hospital site licensed under part 215 to another hospital site licensed under the same license as the hospital seeking to transfer the beds if both hospitals are located within a 2-mile radius of each other.

(b) Subject to subsections (7) and (8), the physical relocation of licensed beds from a hospital licensed under part 215 to a freestanding surgical outpatient facility licensed under part 208 if that freestanding surgical outpatient facility satisfies each of the following criteria on December 2, 2002:

(i) Is owned by, is under common control of, or has as a common parent the hospital seeking to relocate its licensed beds.

(ii) Was licensed prior to January 1, 2002.

(iii) Provides 24-hour emergency care services at that site.

(iv) Provides at least 4 different covered clinical services at that site.

(c) Subject to subsections (7) and (8), the physical relocation of licensed beds from a hospital licensed under part 215 to another hospital licensed under part 215 within the same health service area if the hospital receiving the licensed beds is owned by, is under common control of, or has as a common parent the hospital seeking to relocate its licensed beds.

(4) Subject to subsection (5), a hospital licensed under part 215 is not required to obtain a certificate of need to provide 1 or more of the covered clinical services listed in section 22203(10) in a federal veterans health care facility or to use long-term care unit beds or acute care beds that are owned and located in a federal veterans health care facility if the hospital satisfies each of the following criteria:

(a) The hospital has an active affiliation or sharing agreement with the federal veterans health care facility.

(b) The hospital has physicians who have faculty appointments at the federal veterans health care facility or has an affiliation with a medical school that is affiliated with a federal veterans health care facility and has physicians who have faculty appointments at the federal veterans health care facility.

(c) The hospital has an active grant or agreement with the state or federal government to provide 1 or more of the following functions relating to bioterrorism:

(i) Education.

(ii) Patient care.

(iii) Research.

(iv) Training.

(5) A hospital that provides 1 or more covered clinical services in a federal veterans health care facility or uses long-term care unit beds or acute care beds located in a federal veterans health care facility under subsection (4) may not utilize procedures performed at the federal veterans health care facility to demonstrate need or to satisfy a certificate of need review standard unless the covered clinical service provided at the federal veterans health care facility was provided under a certificate of need.

(6) If a hospital licensed under part 215 had fewer than 70 licensed beds on December 1, 2002, that hospital is not required to satisfy the minimum volume requirements under the certificate of need review standards for its existing operating rooms as long as those operating rooms continue to exist at that licensed hospital site.

(7) Before relocating beds under subsection (3)(b), the hospital seeking to relocate its beds shall provide the information requested by the department of consumer and industry services that will allow the department of consumer and industry services to verify the number of licensed beds that were staffed and available for patient care at that hospital as of December 2, 2002. A hospital shall transfer no more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility under subsection (3)(b) or (c) not more than 1 time after the effective date of the amendatory act that added this subsection if the hospital seeking to relocate its licensed beds or another hospital owned by, under common control of, or having as a common parent the hospital seeking to relocate its licensed beds is located in a city that has a population of 750,000 or more.

(8) The licensed beds relocated under subsection (3)(b) or (c) shall not be included as new beds in a hospital or as a new hospital under the certificate of need review standards for hospital beds. One of every 2 beds transferred under subsection (3)(b) up to a maximum of 100 shall be beds that were staffed and available for patient care as of December 2, 2002. A hospital relocating beds under subsection (3)(b) shall not reactivate licensed beds within that hospital that were unstaffed or unavailable for patient care on December 2, 2002 for a period of 5 years after the date of the relocation of the licensed beds under subsection (3)(b).

(9) No licensed beds shall be physically relocated under subsection (3) if 7 or more members of the commission, after the appointment and confirmation of the 6 additional commission members under section 22211 but before June 15, 2003, determine that relocation of licensed beds under subsection (3) may cause great harm and detriment to the access and delivery of health care to the public and the relocation of beds should not occur without a certificate of need.

(10) An applicant seeking a certificate of need for the acquisition of an existing health facility may file a single, consolidated application for the certificate of need if the project results in the acquisition of an existing health facility but does not result in an increase or relocation of licensed beds or the initiation, expansion, or replacement of a covered clinical service. Except as otherwise provided in this subsection, a person acquiring an existing health facility is subject to the applicable certificate of need review standards in effect on the date of the transfer for the covered clinical services provided by the acquired health facility. The department may except 1 or more of the covered clinical services listed in section 22203(10)(b), except the covered clinical service listed in section 22203(10)(b)(iv), from the minimum volume requirements in the applicable certificate of need review standards in effect on the date of the transfer, if the equipment used in the covered clinical service is unable to meet the minimum volume requirements due to the technological incapacity of the equipment. A covered clinical service excepted by the department under this subsection is subject to all the other provisions in the applicable certificate of need review standards in effect on the date of the transfer, except minimum volume requirements.

(11) An applicant seeking a certificate of need for the relocation or replacement of an existing health facility may file a single, consolidated application for the certificate of need if the project does not result in an increase of licensed beds or the initiation, expansion, or replacement of a covered clinical service. A person relocating or replacing an existing health facility is subject to the applicable certificate of need review standards in effect on the date of the relocation or replacement of the health facility.

(12) As used in this section, "sharing agreement" means a written agreement between a federal veterans health care facility and a hospital licensed under part 215 for the use of the federal veterans health care facility's beds or equipment, or both, to provide covered clinical services.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1990, Act 260, Imd. Eff. Oct. 15, 1990;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22210 Certificate of need for extended care services program; application; criteria; modification; fee prohibited; compliance; discrimination prohibited; exercise of rights; written acknowledgment; forms; additional rights; violation; penalty; certificate required; definitions.

Sec. 22210. (1) Subject to this section, a hospital that applies to the department for a certificate of need and meets all of the following criteria shall be granted a certificate of need for an extended care services program with up to 10 licensed hospital beds:

(a) Is eligible to apply for certification as a provider of extended care services through the use of swing beds under section 1883 of title XVIII, 42 USC 1395tt.

(b) Subject to subsection (2), has fewer than 100 licensed beds not counting beds excluded under section 1883 of title XVIII, 42 USC 1395tt.

(c) Does not have uncorrected licensing, certification, or safety deficiencies for which the department or the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, or both, has not accepted a plan of correction.

(d) Provides evidence satisfactory to the department that the hospital has had difficulty in placing patients in skilled nursing home beds during the 12 months immediately preceding the date of the application.

(2) After October 1, 1990, the criteria set forth in subsection (1)(b) may be modified by the commission, using the procedure set forth in section 22215(3). The department shall not charge a fee for processing a certificate of need application to initiate an extended care services program.

(3) A hospital that is granted a certificate of need for an extended care services program under subsection (1) shall comply with all of the following:

(a) Not charge for or otherwise attempt to recover the cost of a length of stay for a patient in the extended care services program that exceeds the length of time allowed for post-hospital extended care under title XVIII.

(b) Admit patients to the extended care services program only pursuant to an admissions contract approved by the department.

(c) Subject to subdivision (f), not discharge or transfer a patient from a licensed hospital bed other than a hospital long-term care unit bed and admit that patient to the extended care services program unless the discharge or transfer and admission is determined medically appropriate by the attending physician.

(d) Permit access to a representative of an organization approved under section 21764 to patients admitted to the extended care services program, for all of the purposes described in section 21763.

(e) Not allow the number of patient days for the extended care services program to exceed the equivalent of 1,825 patient days for a single state fiscal year.

(f) Not provide extended care services in a swing bed if the hospital owns or operates a hospital long-term care unit that has beds available.

(g) Not charge or collect from a patient admitted to the extended care services program, for services rendered as part of the extended care services program, an amount in excess of the reasonable charge for the services as determined by the secretary of the United States department of health and human services under title XVIII.

(h) Assist a patient who has been denied coverage for services received in an extended care services program under title XVIII to file an appeal with the medicare recovery project operated by the office of services to the aging.

(i) Operate the extended care services program pursuant to this section and the provisions of section 1883 of title XVIII, 42 USC 1395tt, that are applicable to the extended care services program.

(j) Provide data to the department considered necessary by the department to evaluate the extended care services program. The data shall include, but are not limited to, all of the following:

(i) The total number of patients admitted to the hospital's extended care services program during the period specified by the department.

(ii) The total number of extended care services patient days for the period specified by the department.

(iii) Information identifying the type of care to which patients in the extended care services program are released.

(k) As part of the hospital's policy describing the rights and responsibilities of patients admitted to the hospital, as required under section 20201, incorporate all of the following additional rights and responsibilities for patients in the extended care services program:

(i) A copy of the hospital's policy shall be provided to each extended care services patient upon admission, and the staff of the hospital shall be trained and involved in the implementation of the policy.

(ii) Each extended care services patient may associate and communicate privately with persons of his or her choice. Reasonable, regular visiting hours, which shall take into consideration the special circumstances of each visitor, shall be established for extended care services patients to receive visitors. An extended care services patient may be visited by the patient's attorney or by representatives of the departments named in section 20156 during other than established visiting hours. Reasonable privacy shall be afforded for visitation of an extended care services patient who shares a room with another extended care services patient. Each extended care services patient shall have reasonable access to a telephone.

(iii) An extended care services patient is entitled to retain and use personal clothing and possessions as space permits, unless medically contraindicated, as documented by the attending physician in the medical record.

(iv) An extended care services patient is entitled to the opportunity to participate in the planning of his or her medical treatment, including the development of the discharge plan under subdivision (m). An extended care services patient shall be fully informed by the attending physician of the extended care services patient's medical condition, unless medically contraindicated, as documented by a physician in the medical record. Each extended care services patient shall be afforded the opportunity to discharge himself or herself from the extended care services program.

(v) An extended care services patient is entitled to be fully informed either before or at the time of admission, and during his or her stay, of services available in the hospital and of the related charges for those services. The statement of services provided by the hospital shall be in writing and shall include those services required to be offered on an as needed basis.

(vi) A patient in an extended care services program or a person authorized in writing by the patient may, upon submission to the hospital of a written request, inspect and copy the patient's personal or medical records. The hospital shall make the records available for inspection and copying within a reasonable time,

not exceeding 7 days, after the receipt of the written request.

(vii) An extended care services patient has the right to have his or her parents, if the extended care services patient is a minor, or his or her spouse, next of kin, or patient's representative, if the extended care services patient is an adult, stay at the hospital 24 hours a day if the extended care services patient is considered terminally ill by the physician responsible for the extended care services patient's care.

(viii) Each extended care services patient shall be provided with meals that meet the recommended dietary allowances for that patient's age and sex and that may be modified according to special dietary needs or ability to chew.

(ix) Each extended care services patient has the right to receive a representative of an organization approved under section 21764, for all of the purposes described in section 21763.

(l) Achieve and maintain medicare certification under title XVIII.

(m) Establish a discharge plan for each extended care services patient who is admitted to the extended care services program. In the discharge plan, the hospital shall emphasize patient choice in receiving extended care services in the most appropriate and least restrictive setting. The hospital shall provide to the patient or his or her authorized representative a copy of the discharge plan not later than 3 days after the patient is admitted to the extended care services program.

(4) A hospital or the owner, administrator, an employee, or a representative of the hospital shall not discharge, harass, or retaliate or discriminate against an extended care services patient because the extended care services patient has exercised a right described in subsection (3)(k).

(5) In the case of an extended care services patient, the rights described in subsection (3)(k)(iv) may be exercised by the patient's representative, as defined in section 21703(2).

(6) An extended care services patient shall be fully informed, as evidenced by the extended care services patient's written acknowledgment, before or at the time of admission and during stay, of the rights described in subsection (3)(k). The written acknowledgment shall provide that if an extended care services patient is adjudicated incompetent and not restored to legal capacity, the rights and responsibilities set forth in subsection (3)(k) shall be exercised by a person designated by the extended care services patient. The hospital shall provide proper forms for the extended care services patient to provide for the designation of this person at the time of admission.

(7) Subsection (3)(k) does not prohibit a hospital from establishing and recognizing additional rights for extended care services patients.

(8) A hospital that violates subsection (3) is subject to the penalty provisions of section 20165.

(9) A person shall not initiate an extended care services program without first obtaining a certificate of need under this section.

(10) As used in this section:

(a) "Extended care services program" means a program by a hospital to provide extended care services to a patient through the use of swing beds under section 1883 of title XVIII, 42 USC 1395tt.

(b) "Hospital long-term care unit" means that term as defined in section 20106.

History: Add. 1988, Act 308, Eff. Oct. 1, 1988;—Am. 1990, Act 260, Imd. Eff. Oct. 15, 1990;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2006, Act 195, Imd. Eff. June 19, 2006;—Am. 2011, Act 51, Eff. Dec. 6, 2011.

Compiler's note: For transfer of powers and duties of state fire marshal to department of labor and economic growth, bureau of construction codes and fire safety, by type II transfer, see E.R.O. No. 2003-1, compiled at MCL 445.2011.

Popular name: Act 368

333.22211 Certificate of need commission; creation; appointment, qualifications, and terms of members; vacancy; laws to which commission members subject.

Sec. 22211. (1) The certificate of need commission is created in the department. The commission shall consist of 11 members appointed by the governor with the advice and consent of the senate. The governor shall not appoint more than 6 members from the same major political party and shall appoint 5 members from another major political party. The members constituting the commission on the day before the effective date of the amendatory act that added subdivision (a) shall serve on the commission for the remainder of their terms. On the expiration of the term of each member constituting the commission on the day before the effective date of the amendatory act that added subdivision (a), the governor shall appoint a successor as required under this section in accordance with subdivisions (f), (g), (h), (i), and (j) and in that order. Of the additional members, the governor, within 30 days after the effective date of the amendatory act that added subdivision (a), shall appoint 6 additional members to the commission as required under subdivisions (a), (b), (c), (d), and (e). The commission shall consist of the following 11 members:

(a) Two individuals representing hospitals.

(b) One individual representing physicians licensed under part 170 to engage in the practice of medicine.

(c) One individual representing physicians licensed under part 175 to engage in the practice of osteopathic medicine and surgery.

(d) One individual who is a physician licensed under part 170 or 175 representing a school of medicine or osteopathic medicine.

(e) One individual representing nursing homes.

(f) One individual representing nurses.

(g) One individual representing a company that is self-insured for health coverage.

(h) One individual representing a company that is not self-insured for health coverage.

(i) One individual representing a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1703.

(j) One individual representing organized labor unions in this state.

(2) In making appointments, the governor shall, to the extent feasible, assure that the membership of the commission is broadly representative of the interests of all of the people of this state and of the various geographic regions.

(3) A member of the commission shall serve for a term of 3 years or until a successor is appointed. Of the 6 members appointed within 30 days after the effective date of the amendatory act that added subsection (1)(a), 2 of the members shall be appointed for a term of 1 year, 2 of the members shall be appointed for a term of 2 years, and 2 of the members shall be appointed for a term of 3 years. A vacancy on the commission shall be filled for the remainder of the unexpired term in the same manner as the original appointment.

(4) Commission members are subject to the following:

(a) 1968 PA 317, MCL 15.321 to 15.330.

(b) 1973 PA 196, MCL 15.341 to 15.348.

(c) 1978 PA 472, MCL 4.411 to 4.431.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22213 Commission; bylaws; removal of member; election of chairperson and vice-chairperson; meetings; quorum; final action; compensation and expenses; duties of department; professional employees.

Sec. 22213. (1) The commission shall, within 2 months after appointment and confirmation of all members, adopt bylaws for the operation of the commission. The bylaws shall include, at a minimum, voting procedures that protect against conflict of interest and minimum requirements for attendance at meetings.

(2) The governor may remove a commission member from office for failure to attend 3 consecutive meetings in a 1-year period.

(3) The commission annually shall elect a chairperson and vice-chairperson.

(4) The commission shall hold regular quarterly meetings at places and on dates fixed by the commission. Special meetings may be called by the chairperson, by not less than 3 commission members, or by the department.

(5) A majority of the commission members appointed and serving constitutes a quorum. Final action by the commission shall be only by affirmative vote of a majority of the commission members appointed and serving. A commission member shall not vote by proxy.

(6) The legislature annually shall fix the per diem compensation of members of the commission. Expenses of members incurred in the performance of official duties shall be reimbursed as provided in section 1216.

(7) The department shall furnish administrative services to the commission, shall have charge of the commission's offices, records, and accounts, and shall provide at least 2 full-time administrative employees, secretarial staff, and other staff necessary to allow the proper exercise of the powers and duties of the commission. The department shall make available the times and places of commission meetings and keep minutes of the meetings and a record of the actions of the commission. The department shall make available a brief summary of the actions taken by the commission.

(8) The department shall assign at least 2 full-time professional employees to staff the commission to assist the commission in the performance of its substantive responsibilities under this part.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22215 Duties of commission; purpose; public hearing before final action; submission of proposed final action to joint committee; approval or disapproval; review standards; revision of fees.

Sec. 22215. (1) The commission shall do all of the following:

(a) If determined necessary by the commission, revise, add to, or delete 1 or more of the covered clinical services listed in section 22203. If the commission proposes to add to the covered clinical services listed in section 22203, the commission shall develop proposed review standards and make the review standards available to the public not less than 30 days before conducting a hearing under subsection (3).

(b) Develop, approve, disapprove, or revise certificate of need review standards that establish for purposes of section 22225 the need, if any, for the initiation, replacement, or expansion of covered clinical services, the acquisition or beginning the operation of a health facility, making changes in bed capacity, or making covered capital expenditures, including conditions, standards, assurances, or information that must be met, demonstrated, or provided by a person who applies for a certificate of need. A certificate of need review standard may also establish ongoing quality assurance requirements including any or all of the requirements specified in section 22225(2)(c). Except for nursing home and hospital long-term care unit bed review standards, by January 1, 2004, the commission shall revise all certificate of need review standards to include a requirement that each applicant participate in title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and 1396r-8 to 1396v.

(c) Direct the department to prepare and submit recommendations regarding commission duties and functions that are of interest to the commission including, but not limited to, specific modifications of proposed actions considered under this section.

(d) Approve, disapprove, or revise proposed criteria for determining health facility viability under section 22225.

(e) Annually assess the operations and effectiveness of the certificate of need program based on periodic reports from the department and other information available to the commission.

(f) By January 1, 2005, and every 2 years thereafter, make recommendations to the joint committee regarding statutory changes to improve or eliminate the certificate of need program.

(g) Upon submission by the department approve, disapprove, or revise standards to be used by the department in designating a regional certificate of need review agency, pursuant to section 22226.

(h) Develop, approve, disapprove, or revise certificate of need review standards governing the acquisition of new technology.

(i) In accordance with section 22255, approve, disapprove, or revise proposed procedural rules for the certificate of need program.

(j) Consider the recommendations of the department and the department of attorney general as to the administrative feasibility and legality of proposed actions under subdivisions (a), (b), and (c).

(k) Consider the impact of a proposed restriction on the acquisition of or availability of covered clinical services on the quality, availability, and cost of health services in this state.

(l) If the commission determines it necessary, appoint standard advisory committees to assist in the development of proposed certificate of need review standards. A standard advisory committee shall complete its duties under this subdivision and submit its recommendations to the commission within 6 months unless a shorter period of time is specified by the commission when the standard advisory committee is appointed. An individual shall serve on no more than 2 standard advisory committees in any 2-year period. The composition of a standard advisory committee shall not include a lobbyist registered under 1978 PA 472, MCL 4.411 to 4.431, but shall include all of the following:

(i) Experts with professional competence in the subject matter of the proposed standard, who shall constitute a 2/3 majority of the standard advisory committee.

(ii) Representatives of health care provider organizations concerned with licensed health facilities or licensed health professions.

(iii) Representatives of organizations concerned with health care consumers and the purchasers and payers of health care services.

(m) In addition to subdivision (b), review and, if necessary, revise each set of certificate of need review standards at least every 3 years.

(n) If a standard advisory committee is not appointed by the commission and the commission determines it necessary, submit a request to the department to engage the services of private consultants or request the department to contract with any private organization for professional and technical assistance and advice or other services to assist the commission in carrying out its duties and functions under this part.

(o) Within 6 months after the appointment and confirmation of the 6 additional commission members under section 22211, develop, approve, or revise certificate of need review standards governing the increase of licensed beds in a hospital licensed under part 215, the physical relocation of hospital beds from 1 licensed site to another geographic location, and the replacement of beds in a hospital licensed under part 215.

(2) The commission shall exercise its duties under this part to promote and assure all of the following:

(a) The availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in this state.

(b) Appropriate differential consideration of the health care needs of residents in rural counties in ways that do not compromise the quality and affordability of health care services for those residents.

(3) Not less than 30 days before final action is taken by the commission under subsection (1)(a), (b), (d), (h), or (o), the commission shall conduct a public hearing on its proposed action. In addition, not less than 30 days before final action is taken by the commission under subsection (1)(a), (b), (d), (h), or (o), the commission chairperson shall submit the proposed action and a concise summary of the expected impact of the proposed action for comment to each member of the joint committee. The commission shall inform the joint committee of the date, time, and location of the next meeting regarding the proposed action. The joint committee shall promptly review the proposed action and submit its recommendations and concerns to the commission.

(4) The commission chairperson shall submit the proposed final action including a concise summary of the expected impact of the proposed final action to the governor and each member of the joint committee. The governor or the legislature may disapprove the proposed final action within 45 days after the date of submission. If the proposed final action is not submitted on a legislative session day, the 45 days commence on the first legislative session day after the proposed final action is submitted. The 45 days shall include not less than 9 legislative session days. Legislative disapproval shall be expressed by concurrent resolution which shall be adopted by each house of the legislature. The concurrent resolution shall state specific objections to the proposed final action. A proposed final action by the commission under subsection (1)(a), (b), (d), (h), or (o) is not effective if it has been disapproved under this subsection. If the proposed final action is not disapproved under this subsection, it is effective and binding on all persons affected by this part upon the expiration of the 45-day period or on a later date specified in the proposed final action. As used in this subsection, "legislative session day" means each day in which a quorum of either the house of representatives or the senate, following a call to order, officially convenes in Lansing to conduct legislative business.

(5) The commission shall not develop, approve, or revise a certificate of need review standard that requires the payment of money or goods or the provision of services unrelated to the proposed project as a condition that must be satisfied by a person seeking a certificate of need for the initiation, replacement, or expansion of covered clinical services, the acquisition or beginning the operation of a health facility, making changes in bed capacity, or making covered capital expenditures. This subsection does not preclude a requirement that each applicant participate in title XIX of the social security act, chapter 531, 49 Stat. 620, 1396r-6 and 1396r-8 to 1396v, or a requirement that each applicant provide covered clinical services to all patients regardless of his or her ability to pay.

(6) If the reports received under section 22221(f) indicate that the certificate of need application fees collected under section 20161 have not been within 10% of 3/4 the cost to the department of implementing this part, the commission shall make recommendations regarding the revision of those fees so that the certificate of need application fees collected equal approximately 3/4 of the cost to the department of implementing this part.

(7) As used in this section, "joint committee" means the joint committee created under section 22219.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22217 Repealed. 2002, Act 619, Eff. Mar. 31, 2003.

Compiler's note: The repealed section pertained to certificate of need review standards.

Popular name: Act 368

333.22219 Joint legislative committee.

Sec. 22219. (1) A joint legislative committee to focus on proposed actions of the commission regarding the certificate of need program and certificate of need standards and to review other certificate of need issues is created. The joint committee shall consist of 6 members as follows:

- (a) The chairperson of the senate committee on health policy.
- (b) The vice-chairperson of the senate committee on health policy.
- (c) The minority vice-chairperson of the senate committee on health policy.
- (d) The chairperson of the house of representatives committee on health policy.
- (e) The vice-chairperson of the house of representatives committee on health policy.
- (f) The minority vice-chairperson of the house of representatives committee on health policy.

(2) The joint committee shall be co-chaired by the chairperson of the senate committee on health policy

and the chairperson of the house committee on health policy.

(3) The joint committee may administer oaths, subpoena witnesses, and examine the application, documentation, or other reports and papers of an applicant or any other person involved in a matter properly before the committee.

(4) The joint committee shall review the recommendations made by the commission under section 22215(6) regarding the revision of the certificate of need application fees and submit a written report to the legislature outlining the costs to the department to implement the program, the amount of fees collected, and its recommendation regarding the revision of those fees.

(5) The joint committee may develop a plan for the revision of the certificate of need program. If a plan is developed by the joint committee, the joint committee shall recommend to the legislature the appropriate statutory changes to implement the plan.

History: Add. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22221 Duties of department generally.

Sec. 22221. The department shall do all of the following:

(a) Subject to approval by the commission, promulgate rules to implement its powers and duties under this part.

(b) Report to the commission at least annually on the performance of the department's duties under this part.

(c) Develop proposed certificate of need review standards for submission to the commission.

(d) Administer and apply certificate of need review standards. In the review of certificate of need applications, the department shall consider relevant written communications from any person.

(e) Designate adequate staff or other resources to directly assist hospitals and nursing homes with less than 100 beds in the preparation of applications for certificates of need.

(f) By October 1, 2003, and annually thereafter, report to the commission regarding the costs to the department of implementing this part and the certificate of need application fees collected under section 20161 in the immediately preceding state fiscal year.

(g) Beginning January 1, 2003, annually adjust the \$2,500,000.00 threshold set forth in section 22203(9) by an amount determined by the state treasurer to reflect the annual percentage change in the consumer price index, using data from the immediately preceding period of July 1 to June 30. As used in this subdivision, "consumer price index" means the most comprehensive index of consumer prices available for this state from the bureau of labor statistics of the United States department of labor.

(h) Annually review the application process, including all forms, reports, and other materials that are required to be submitted with the application. If needed to promote administrative efficiency, revise the forms, reports, and any other materials required with the application.

(i) Within 6 months after the effective date of the amendatory act that added this subdivision, create a consolidated application for a certificate of need for the relocation or replacement of an existing health facility.

(j) In consultation with the commission, define single project as it applies to capital expenditures.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22223 Application for certificate of need; statement addressing review criteria.

Sec. 22223. An applicant for a certificate of need shall include as part of the application a statement addressing each of the review criteria listed in section 22225. This section does not apply to an application for a certificate of need made under section 22210.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22224 Certificate of need not required.

Sec. 22224. (1) A health facility required to be licensed as a freestanding surgical outpatient facility by rules promulgated under section 20115(2) is not required to obtain a certificate of need in order to be granted a license as a freestanding surgical outpatient facility.

(2) If a freestanding surgical outpatient facility is applying for a certificate of need to initiate, replace, or expand a covered clinical service consisting of surgical services, the department shall not count abortion procedures in determining if the freestanding surgical outpatient facility meets the annual minimum number

of surgical procedures required in the certificate of need standards governing surgical services.

History: Add. 1999, Act 206, Eff. Mar. 10, 2000.

Popular name: Act 368

333.22224a Magnetic resonance image units.

Sec. 22224a. (1) A person seeking to initiate, expand, replace, relocate, or acquire a fixed or mobile magnetic resonance imager service within a county that has a population of more than 160,000 but does not have at least 2 magnetic resonance imager units may file a letter of intent with the department prior to the initiation, expansion, replacement, relocation, or acquisition of a fixed or mobile magnetic resonance imager unit within that county instead of obtaining a certificate of need.

(2) Within 30 days after receiving the letter of intent, if the department verifies that the county has a population of more than 160,000 and that the county does not already have 2 magnetic resonance imager units, the department shall send a written acknowledgment to the person approving the initiation, expansion, replacement, relocation, or acquisition of a fixed or mobile magnetic resonance imager unit.

(3) A person shall not initiate, expand, replace, relocate, or acquire a fixed or mobile magnetic resonance imager unit under this section without a certificate of need unless that person receives a written acknowledgment of approval from the department under subsection (2).

(4) A person seeking to initiate, expand, replace, relocate, or acquire a fixed or mobile magnetic resonance imager service under this section shall be a nonprofit organization and shall demonstrate that the service shall be accessible to all patients regardless of his or her ability to pay and shall participate in title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-8 to 1396v.

History: Add. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22225 Demonstration of need for proposed project; additional requirements.

Sec. 22225. (1) In order to be approved under this part, an applicant for a certificate of need shall demonstrate to the satisfaction of the department that the proposed project will meet an unmet need in the area proposed to be served. An applicant shall demonstrate the need for a proposed project by credible documentation of compliance with the applicable certificate of need review standards. If no certificate of need review standards are applicable to the proposed project or to a portion of a proposed project that is otherwise governed by this part, the applicant shall demonstrate to the satisfaction of the department that an unmet need for the proposed project or portion of the proposed project exists by credible documentation that the proposed project will be geographically accessible and efficiently and appropriately utilized, in light of the type of project and the existing health care system. Whether or not there are applicable certificate of need review standards, in determining compliance with this subsection, the department shall consider approved projects that are not yet operational, proposed projects under appeal from a final decision of the department, or proposed projects that are pending final department decision.

(2) If, and only if, the requirements of subsection (1) are met, in order for an application to be approved under this part, an applicant shall also demonstrate to the reasonable satisfaction of the department all of the following:

(a) With respect to the method proposed to meet the unmet need identified under subsection (1), that the applicant has considered alternatives to the proposed project and that, in light of the alternatives available for consideration, the chosen alternative is the most efficient and effective method of meeting that unmet need.

(b) With respect to the financial aspects of the proposed project, that each of the following is met:

(i) The capital costs of the proposed project will result in the least costly total annual operating costs.

(ii) Funds are available to meet the capital and operating needs of the proposed project.

(iii) The proposed project utilizes the least costly method of financing, in light of available alternatives.

(iv) In the case of a construction project, the applicant stipulates that the applicant will competitively bid capital expenditures among qualified contractors or alternatively, the applicant is proposing an alternative to competitive bidding that will achieve substantially the same results as competitive bidding.

(c) The proposed project will be delivered in compliance with applicable operating standards and quality assurance standards approved under section 22215(1)(b), including 1 or more of the following:

(i) Mechanisms for assuring appropriate utilization of the project.

(ii) Methods for evaluating the effectiveness of the project.

(iii) Means of assuring delivery of the project by qualified personnel and in compliance with applicable safety and operating standards.

(iv) Evidence of the current and historical compliance with federal and state licensing and certification requirements in this state by the applicant or the applicant's owner, or both, to the degree determined

appropriate by the commission in light of the subject of the review standard.

(v) Other criteria approved by the commission as appropriate to evaluate the quality of the project.

(d) The health services proposed in the project will be delivered in a health facility that meets the criteria, if any, established by the commission for determining health facility viability, pursuant to this subdivision. The criteria shall be proposed by the department and the office, and approved or disapproved by the commission. At a minimum, the criteria shall specify, to the extent applicable to the applicant, that an applicant shall be considered viable by demonstrating at least 1 of the following:

(i) A minimum percentage occupancy of licensed beds.

(ii) A minimum percentage of combined uncompensated discharges and discharges under title XIX in the health facility's planning area.

(iii) A minimum percentage of the total discharges in the health facility's planning area.

(iv) Evidence that the health facility is the only provider in the health facility's planning area of a service that is considered essential by the commission.

(v) An operating margin in an amount determined by the commission.

(vi) Other criteria approved by the commission as appropriate for statewide application to determine health facility viability.

(e) In the case of a nonprofit health facility, the health facility is in fact governed by a body composed of a majority consumer membership broadly representative of the population served. In the case of a health facility sponsored by a religious organization, or if the nature of the nonprofit health facility is such that the legal rights of its owners or sponsors might be impaired by a requirement as to the composition of its governing body, an advisory board with majority consumer membership broadly representative of the population served may be construed by the department to be equivalent to the governing board described in this subdivision, if the advisory board meets all of the following requirements:

(i) The role assigned to the advisory board is meaningful, as determined by the department.

(ii) The functions of the advisory board are clearly prescribed.

(iii) The advisory board is given an opportunity to influence policy formulation by the legally recognized governing body, as determined by the department.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993.

Popular name: Act 368

333.22226 Regional certificate of need review agency; standards; designation of person for specific review area; requirements; duration and termination of agency; local certificate of need review agency; application or other information; review; recommendations; decision; convening consumers, providers, purchasers, or payers of health care; public hearing; meetings; “review area” defined.

Sec. 22226. (1) The commission shall develop standards for the designation by the department of a regional certificate of need review agency for each review area to develop advisory recommendations for proposed projects. The standards shall be based on the requirements for a regional certificate of review agency set forth in subsection (3).

(2) The department, with the concurrence of the commission, shall designate a person to be a regional certificate of need review agency for a specific review area, according to procedures approved by the commission, if the person meets the standards approved under subsection (1), and if a regional certificate of need review agency has not already been designated for that specific review area.

(3) A regional certificate of need review agency shall meet all of the following requirements:

(a) Be an independent nonprofit organization that is not a subsidiary of, or otherwise controlled by, any other person.

(b) Be governed by a board that is broadly representative of consumers, providers, payers, and purchasers of health care in the review area, with a majority of the board being consumers, payers, and purchasers of health care.

(c) Demonstrate a willingness and ability to conduct reviews of all proposed projects requiring a certificate of need that would be located within the review area served by the regional certificate of need review agency.

(d) Avoid conflict of interest in its review of all applications for a certificate of need.

(e) Provide data to the department to enable the department to evaluate the regional certificate of need review agency's performance. The data provided under this subdivision shall be reviewed at periodic meetings between the department and the regional certificate of need review agency.

(f) Not receive more than a designated proportion of its financial support from health facilities and health professionals, as determined by the commission.

(g) Meet other requirements established by the commission that are relevant to the functions of a regional certificate of need review agency, under this part.

(4) The designation of a regional certificate of need review agency shall be operative for a period of time approved by the commission, but not for more than 24 months. The designation of a regional certificate of need review agency may be terminated by the department with the concurrence of the commission at any time for noncompliance with the standards approved under subsection (1). In addition, the designation may be terminated by the regional certificate of need review agency upon the expiration of 60 days after the department receives written notice of the termination.

(5) A local certificate of need review agency that was designated pursuant to a designation agreement authorized under former section 22124 and effective on October 1, 1988 is designated as the regional certificate of need review agency for its review area until the expiration of 1 year after the date of final approval of the standards developed under subsection (1), unless the designation is terminated by either the department under subsection (4) or the regional certificate of need review agency before that time.

(6) A person applying for a certificate of need under this part shall simultaneously provide a copy of any letter of intent, application, or additional information required by the department to the regional certificate of need review agency designated by the department for the review area in which the proposed project would be located, unless the regional certificate of need review agency determines that it will not review the application or other information, and notifies both the applicant and the department in writing of its determination. The regional certificate of need review agency may review the application and submit its recommendations to the department. If the regional certificate of need review agency determines that it will not review the application, then the regional certificate of need review agency shall notify both the applicant and the department in writing of its determination. In developing its recommendations, the regional certificate of need review agency shall utilize the review procedures and time frames specified for regional certificate of need review agencies in the rules continued or promulgated under this part, and shall also utilize certificate of need review standards, statutory criteria, and forms identical to those used by the department.

(7) Before developing a proposed decision on an application, the department shall review the recommendations of the regional certificate of need review agency for the review area in which the proposed project would be located, if the recommendations are submitted to the department within the time frames required under subsection (6). If the director makes a final decision that is inconsistent with the recommendations of the regional certificate of need review agency, the department shall promptly provide the regional certificate of need review agency with a detailed statement of the reasons for the director's decision. The statement shall address each instance in which the director's decision is inconsistent with the recommendation of the regional certificate of need review agency regarding a specific certificate of need review standard or criterion.

(8) A regional certificate of need review agency may convene consumers, providers, purchasers, or payers of health care, or representatives of all of those groups, related to activities in its review area for the purpose of achieving the objectives of this part.

(9) Before developing a recommendation on a certificate of need application, a regional certificate of need review agency shall hold a public hearing on the proposed project. If the department determines that local interest merits a public hearing and a regional certificate of need review agency has not been designated for the review area in which the proposed project will be located, then the department shall hold a public hearing on the proposed project.

(10) A regional certificate of need review agency shall conduct all meetings regarding its activities for the purpose of achieving the objectives of this part in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

(11) As used in this section, "review area" means a geographic area established for a health systems agency pursuant to former section 1511 of the public health service act, or a geographic area otherwise established by the commission for a regional certificate of need review agency.

History: Add. 1988, Act 331, Eff. Oct. 1, 1988;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

Administrative rules: R 325.9101 et seq. of the Michigan Administrative Code.

333.22227 Health maintenance organization; purposes for which certificate of need required; capital expenditures; considerations and criteria.

Sec. 22227. (1) A health maintenance organization is required to obtain a certificate of need only for 1 or more of the following purposes:

(a) The acquisition of, purchase of, new construction of, modernization of, replacement of, or addition to a

hospital or other health facility providing inpatient services, if a covered capital expenditure is required.

(b) The initiation, replacement, or expansion of a covered clinical service.

(2) A covered capital expenditure proposed to be undertaken by a health maintenance organization that is not intended principally to serve the needs of the enrollees of the health maintenance organization, as determined by the department, is subject to this part.

(3) In making determinations and conducting reviews for certificates of need for health maintenance organizations, the department shall consider the special needs and circumstances of health maintenance organizations, and shall apply all of the following criteria:

(a) The availability of the proposed service from a provider of health care other than the health maintenance organization on a long-term basis, at reasonable terms, and in a cost-effective manner consistent with the health maintenance organization's basic method of operation.

(b) The long-term needs of the health maintenance organization, and its current and expected future membership.

(c) The long-term impact of the proposed service on health care costs in the health maintenance organization's service area.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993.

Popular name: Act 368

333.22229 Projects and services subject to comparative review; exceptions; establishment of comparative review or alternative procedure; proposed site for project; utilization and financing of covered clinical services.

Sec. 22229. (1) The following proposed projects are subject to comparative review:

(a) Proposed projects specified as subject to comparative review in a certificate of need review standard.

(b) New beds in a health facility that is a hospital, hospital long-term care unit, or nursing home if there are multiple applications to meet the same need for projects that, when combined, exceed the need of the planning area as determined by the applicable certificate of need review standards.

(2) Replacement beds in a hospital that are proposed for construction on the original site, on a contiguous site, within a 5-mile radius of the original site if the hospital is located in a county with a population of less than 200,000, or within a 2-mile radius of the original site if the hospital is located in a county with a population of 200,000 or more, are not subject to comparative review.

(3) Replacement beds in a nursing home that is located in a nonrural county that are proposed for construction on the original site, on a contiguous site, or within a 2-mile radius of the original site are not subject to comparative review. Replacement beds in a nursing home that is located in a rural county that are proposed for construction on the original site, on a contiguous site, or within the same planning area are not subject to comparative review.

(4) The commission may approve certificate of need review standards that establish comparative review or an alternative procedure for determining whether 1 or more of several qualified applicants may be approved if the level of need is not sufficient to justify approval of all qualified applicants. If an applicant involves more than 1 health facility, the applicant shall indicate on the application the proposed site or sites for the project and arrangements for the utilization and financing of the covered clinical services.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993.

Popular name: Act 368

333.22230 Participation in medicaid program as distinct criterion.

Sec. 22230. In evaluating applications for a health facility as defined under section 22205(1)(c) in a comparative review, the department shall include participation in title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v, as a distinct criterion, weighted as very important, and determine the degree to which an application meets this criterion based on the extent of participation in the medicaid program.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22231 Decision to grant or deny application for certificate of need; conditions; single decision for all applications; proposed decision; final decision; notice of reversal; hearing; judicial review; effect of exceeding time frames.

Sec. 22231. (1) The decision to grant or deny an application for a certificate of need shall be made by the director. A decision shall be proposed to the director by a bureau within the department designated by the

director as responsible for the certificate of need program. A decision shall be in writing and shall indicate 1 of the following:

- (a) Approval of the application.
- (b) Disapproval of the application.
- (c) Subject to subsection (2), approval of the application with conditions.
- (d) If agreed to by the department and the applicant, approval of the application with stipulations.

(2) If an application is approved with conditions under subsection (1)(c), the conditions shall be explicit, shall be related to the proposed project or to the applicable provisions of this part, and shall specify a time, not to exceed 1 year after the date the decision is rendered, within which the conditions shall be met.

(3) If the department is conducting a comparative review, the director shall issue only 1 decision for all of the applications included in the comparative review.

(4) Before a final decision on an application is made, the bureau of the department designated by the director as responsible for the certificate of need program shall issue a proposed decision with specific findings of fact in support of the proposed decision with regard to each of the criteria listed in section 22225. The proposed decision also shall state with specificity the reasons and authority of the department for the proposed decision. The department shall transmit a copy of the proposed decision to the applicant.

(5) The proposed decision shall be submitted to the director on the same day the proposed decision is issued.

(6) If the proposed decision is other than an approval without conditions or stipulations, the director shall issue a final decision not later than 60 days after the date a proposed decision is submitted to the director unless the applicant has filed a request for a hearing on the proposed decision. If the proposed decision is an approval, the director shall issue a final decision not later than 5 days after the proposed decision is submitted to the director.

(7) The director shall review the proposed decision before a final decision is rendered.

(8) If a proposed decision is an approval, and if, upon review, the director reverses the proposed decision, the director immediately shall notify the applicant of the reversal. Within 15 days after receipt of the notice of reversal, the applicant may request a hearing under section 22232. After the hearing, the applicant may request the director to reconsider the reversal of the proposed decision, based on the results of the hearing.

(9) Within 30 days after the final decision of the director, the final decision of the director may be appealed only by the applicant and only on the record directly to the circuit court for the county where the applicant has its principal place of business in this state or the circuit court for Ingham county. Judicial review is governed by the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(10) If the department exceeds the time set forth in this section for other than good cause, as determined by the commission, upon the written request of an applicant, the department shall return to the applicant all of the certificate of need application fee paid by the applicant under section 20161.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22232 Hearing; written request; appointment and duties of hearing officer; governing law.

Sec. 22232. (1) The applicant may, within 15 days after receipt by the applicant of the bureau's proposed decision to deny the application or receipt of notice of reversal by the director of a proposed decision that is an approval, submit a written request for a hearing to demonstrate that the application filed by the applicant meets the requirements for approval under this part.

(2) The department shall appoint a hearing officer for a hearing held under this section. The hearing officer shall establish a schedule for the hearing, control the presentation of proofs, and take such other action determined by the hearing officer to be necessary to ensure that the hearing is conducted in an expeditious manner and completed within a reasonable period of time. The hearing officer shall convene the hearing within 90 days after receipt of a request for a hearing under this section. Upon written request by a party, a hearing officer may issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence. The department shall establish appropriate qualifications for hearing officers appointed under this section.

(3) If a hearing is requested under this section, chapter 4 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws, governs.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993.

Popular name: Act 368

333.22233 Waiver of criteria and procedures.

Sec. 22233. If the department determines that a proposed project is nonsubstantive in nature and does not warrant a full review, the department may waive certain criteria and procedures otherwise required under this part.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22235 Waiver of law and procedural requirements and criteria for review; affidavit; emergency certificate of need.

Sec. 22235. (1) The department may waive otherwise applicable provisions of this part and procedural requirements and criteria for review upon a showing by the applicant, by affidavit, of all of the following:

(a) The necessity for immediate or temporary relief due to natural disaster, fire, unforeseen safety consideration, or other emergency circumstances.

(b) The serious adverse effect of delay on the applicant and the community that would be occasioned by compliance with the otherwise applicable requirements of this part and rules promulgated under this part.

(c) The lack of substantial change in facilities or services that existed before the emergency circumstances established under subdivision (a).

(d) The temporary nature of the construction of facilities or the services that will not preclude different disposition of longer term determinations in a subsequent application for a certificate of need not made under this section.

(2) The department may issue an emergency certificate of need after necessary and appropriate review. A record of the review shall be made, including copies of affidavits and other documentation. Findings and conclusions shall be made as to an application for an emergency certificate of need, whether the emergency certificate of need is issued or denied.

(3) An emergency certificate of need issued under this section is a final decision and the applicant is not required to submit a formal application for a second review. A certificate of need issued under this section may be subject to special limitations and restrictions, in regard to duration and right of extension or renewal and other factors, imposed by the department.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22237 Data and statistics as condition precedent to issuance of certificate of need.

Sec. 22237. As a condition precedent to the issuance of a certificate of need, the department may require that a health facility provide the department with data and statistics determined necessary by the department to carry out departmental duties required under this part, if the data and statistics have not already been reported to the department in a usable format.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22239 Stipulation.

Sec. 22239. (1) If the certificate of need approval was based on a stipulation that the project would participate in title XIX and the project has not participated in title XIX for at least 12 consecutive months within the first 2 years of operation or continued to participate annually thereafter, the department shall revoke the certificate of need. A stipulation described in this section is germane to all health facility projects.

(2) The department shall monitor the participation in title XIX of each certificate of need applicant approved under this part. Except as otherwise provided in subsection (3), the department shall require each applicant to provide verification of participation in title XIX with its application and annually thereafter.

(3) The department shall not revoke or deny a certificate of need for a nursing home licensed under part 217 if that nursing home does not participate in title XIX on the effective date of the amendatory act that added this subsection but agrees to participate in title XIX if beds become available. This section does not prohibit a person from applying for and obtaining a certificate of need to acquire or begin operation of a nursing home that does not participate in title XIX.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22241 “New technology” defined; new technology review period; conditions to acquisition of new technology before end of review period; appointment, composition, and purpose of standing new medical technology advisory committee.

Sec. 22241. (1) For purposes of this section and section 22243, “new technology” means medical equipment that requires, but has not yet been granted, the approval of the federal food and drug administration for commercial use.

(2) The period ending 12 months after the date of federal food and drug administration approval of new technology for commercial use shall be considered the new technology review period. A person shall not acquire new technology before the end of a new technology review period, unless 1 of the following occurs:

(a) The department, with the concurrence of the commission, issues a public notice that the new technology will not be added to the list of covered medical equipment during the new technology review period. The notice may apply to specific new technology or classes of new technology.

(b) The person complies with the requirements of section 22243.

(c) The commission approves the addition of the new technology to the list of covered medical equipment, and the person obtains a certificate of need for that covered medical equipment.

(3) To assist in the identification of new medical technology or new medical services that may be appropriate for inclusion as a covered clinical service in the earliest possible stage of its development, the commission shall appoint a standing new medical technology advisory committee. A majority of the new medical technology advisory committee shall be representatives of health care provider organizations concerned with licensed health facilities or licensed health professions and other persons knowledgeable in medical technology. The commission also shall appoint representatives of health care consumer, purchaser, and third party payer organizations to the committee. The commission shall also appoint faculty members from schools of medicine, osteopathy, and nursing in this state.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22243 Acquisition of new technology before approval of federal food and drug administration; notice; requirements; deactivation and removal of new technology from service; conditions to utilizing new technology beyond specified period.

Sec. 22243. (1) Unless the commission provides otherwise in a standard approved under section 22215(1)(h), a person may acquire new technology before the new technology is approved by the federal food and drug administration if the person notifies the department before acquiring the new technology, and the acquisition of the new technology continuously meets all of the following requirements:

(a) Has been authorized by the federal food and drug administration under an investigational device exemption and approved research project pursuant to 21 C.F.R. part 812.

(b) Is operated consistently with the research protocols established and approved by the federal food and drug administration for the investigational device exemption.

(c) Is solely related to research and testing for purposes of determining the safety and effectiveness of the new technology for use on human subjects.

(d) Is funded so that there will be no recovery of either capital or operating expenses for the use of the new technology either from patients or from third party payers. However, usual and customary charges or other payment arrangements for related services rendered to patients that are consistent with standard nonexperimental treatment, including, but not limited to, room, board, ancillary services, and outpatient services may be charged to patients or third party payers, or both, in accordance with normal billing practices. Each patient upon whom the new technology is used shall be informed of the requirements of this subdivision.

(e) Is maintained under a separate cost center that includes overhead costs, for expenditure reporting related to the research project.

(f) Is developed so that capital funding for the research project will be obtained from sources other than the Michigan state hospital finance authority or any other governmentally supported financing source. This subdivision does not prohibit a person from using grants for research activities.

(g) Is operated so as to provide, upon request of the department, data obtained from the research project that the department may use in developing certificate of need review standards relative to the new technology. Aggregate data obtained as part of a federally approved data set shall meet the requirements of this part, except that supplemental data may be requested by the department.

(h) Is not marketed or advertised to other health care providers or the public.

(2) A person acquiring new technology under this section shall deactivate and remove the new technology from service on the date of notice that federal approval under the investigational device exemption for the new technology acquired under 21 C.F.R. part 812 has expired or been withdrawn, or the date of receipt of a department compliance order alleging a violation of this section.

(3) A person may continue to utilize new technology acquired under this section beyond the period specified in subsection (2) if any 1 of the following applies:

(a) The continued use is in compliance with section 22243(1)(d) to (h).

(b) The department issues a notice that the new technology will not be added to the list of covered medical equipment pursuant to section 22241(2)(a).

(c) The commission adds the new technology to the list of covered medical equipment, and the continued use is consistent with applicable certificate of need review standards, if any.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22247 Monitoring compliance with certificates of need; investigating allegations of noncompliance; violation; sanctions; refund of charges.

Sec. 22247. (1) The department shall monitor compliance with all certificates of need issued under this part and shall investigate allegations of noncompliance with a certificate of need or this part.

(2) If the department determines that the recipient of a certificate of need under this part is not in compliance with the terms of the certificate of need or that a person is in violation of this part or the rules promulgated under this part, the department shall do 1 or more of the following:

(a) Revoke or suspend the certificate of need.

(b) Impose a civil fine of not more than the amount of the billings for the services provided in violation of this part.

(c) Take any action authorized under this article for a violation of this article or a rule promulgated under this article, including, but not limited to, issuance of a compliance order under section 20162(5), whether or not the person is licensed under this article.

(d) Request enforcement action under section 22253.

(e) Take any other enforcement action authorized by this code.

(f) Publicize or report the violation or enforcement action, or both, to any person.

(g) Take any other action as determined appropriate by the department.

(3) A person shall not charge to, or collect from, another person or otherwise recover costs for services provided or for equipment or facilities that are acquired in violation of this part. If a person has violated this subsection, in addition to the sanctions provided under subsection (2), the person shall, upon request of the person from whom the charges were collected, refund those charges, either directly or through a credit on a subsequent bill.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368

333.22249 Agreement authorizing hospital to lease space and operate beds in another hospital; conditions.

Sec. 22249. (1) Subject to subsection (2), if a hospital has a high occupancy rate, as determined by the department, and if the hospital applies for and is issued a certificate of need for an increase in licensed bed capacity, the department may enter into an agreement with the hospital that would authorize the hospital to lease space and operate beds in another hospital in the same planning area, if the other hospital has a low occupancy rate, as determined by the department.

(2) The department may enter into an agreement authorized under subsection (1) only if all of the following apply:

(a) The hospital issued a certificate of need has a documented history of high occupancy.

(b) The alternative of redistributing the beds within the hospital's licensed bed capacity does not exist.

(c) The agreement will not change the overall supply of beds within the planning area.

(d) New construction is not required.

(e) The department determines that the agreement is necessary to protect the public health, safety, and welfare.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22251 Repealed. 1993, Act 88, Imd. Eff. July 9, 1993.

Compiler's note: The repealed section pertained to plans for reduction of excess hospital beds.

Popular name: Act 368

333.22253 Injunction or other process to restrain or prevent violation.

Sec. 22253. Notwithstanding the existence and pursuit of any other remedy, the department may request the attorney general or prosecuting attorney of the jurisdiction where a capital expenditure is proposed to be or was made to bring an action in the name of the people of this state for an injunction or other process against a person to restrain or prevent a violation of this part or the rules promulgated under this part.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22255 Procedural rules.

Sec. 22255. The department, with the approval of the commission, may promulgate procedural rules to implement this part.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 2002, Act 619, Eff. Mar. 31, 2003.

Popular name: Act 368

333.22257 Certificate of need issued under former part 221.

Sec. 22257. A certificate of need issued under former part 221 has the same effect as a similar certificate of need issued under this part. The holder of the certificate of need is subject to all of the conditions, stipulations, and agreements pertaining to the certificate of need and to the same authority of the department to limit, suspend, revoke, or reinstate the certificate of need as a holder of a certificate of need issued under this part.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988.

Popular name: Act 368

333.22260 Reports of reviews; preparation and publication; statements; recommendations; public examination of applications and written materials on file; providing copies.

Sec. 22260. (1) The department shall prepare and publish monthly reports of reviews conducted under this part. The reports shall include a statement on the status of each pending review and a statement as to each review completed, including statements of the findings and decisions made in the course of the reviews since the last report, and the recommendations of regional certificate of need review agencies.

(2) The department shall make available to the public for examination during all business hours the applications received by them and pertinent written materials on file.

(3) The department, upon request, shall provide copies of an application or part of an application. The department may charge a reasonable fee for the copies.

History: Add. 1988, Act 332, Eff. Oct. 1, 1988;—Am. 1993, Act 88, Imd. Eff. July 9, 1993;—Am. 2002, Act 619, Eff. Mar. 31, 2003

Popular name: Act 368