HOUSE BILL NO. 5252

November 12, 2025, Introduced by Reps. Rogers, VanderWall, Miller, Bierlein, Witwer, Schmaltz, Steckloff, Greene, Wilson, Xiong, Thompson, Paiz, Longjohn, Neyer, Price, Mentzer, Fitzgerald, McKinney, Young, Outman, Neeley, Scott, Brixie, Morgan, Martus, Arbit, McFall, Hope, Breen, Weiss, Snyder, Wozniak, Roth, Frisbie, Aragona, Wooden, Liberati and Herzberg and referred to Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 20106, 20109, 20115, and 20161 (MCL 333.20106, 333.20109, 333.20115, and 333.20161), sections 20106 and 20161 as amended by 2024 PA 252, section 20109 as amended by 2015 PA 156, and section 20115 as amended by 2023 PA 209, and by adding part 219A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 20106. (1) "Health facility or agency", except as provided in section 20115, means:

(a) An ambulance operation, aircraft transport operation, nontransport prehospital life support operation, or medical first response service.

(b) A county medical care facility.

(c) A freestanding surgical outpatient facility.

(d) A health maintenance organization.

(e) A home for the aged.

(f) A hospital.

(g) A nursing home.

(h) A hospice.

(i) A hospice residence.

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

(k) A freestanding birth center.

(*l*) Beginning October 1, 2026, a prescribed pediatric extended care center.

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

(3) "Home for the aged" means a supervised personal care facility at a single address, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility that provides room, board, and supervised personal care to 21 or more unrelated, nontransient individuals 55 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 55 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home. Home for the aged does not include an area excluded from this definition by section 17(3) of the continuing care

community disclosure act, 2014 PA 448, MCL 554.917.

(4) "Hospice" means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(5) "Hospital" means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. Hospital does not include a mental health hospital licensed or operated by the department of health and human services or a hospital operated by the department of corrections.

(6) "Hospital long-term care unit" means a nursing care facility, owned and operated by and as part of a hospital, providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

Sec. 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. As used in this subsection, "medical treatment" includes treatment by an employee or independent contractor of the nursing home who is an individual licensed or otherwise authorized to engage in a health profession under part 170 or 175. Nursing home does not include any of the following:

(a) A unit in a state correctional facility.

(b) A hospital.

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

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

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

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

(3) "Prescribed pediatric extended care center" means that term as defined in section 21951.

(4) ~~(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 resident 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 resident contract.

(5) ~~(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.

Sec. 20115. 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)~~ **20109(5)** 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.

Sec. 20161. (1) The department shall assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Until October 1, 2027, except as otherwise provided in this article, fees and assessments must be paid as provided in the following schedule:

(a) Freestanding surgical outpatient facilities	$500.00 per facility license.
(b) Hospitals	$500.00 per facility license and $10.00 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units	$500.00 per facility license and $3.00 per licensed bed over 100 licensed beds.
(d) Homes for the aged	$500.00 per facility license and $6.27 per licensed bed.
(e) Hospice agencies	$500.00 per agency license.
(f) Hospice residences	$500.00 per facility license and $5.00 per licensed bed.
(g) Freestanding birth center	$500.00 per facility license.
(h) Prescribed pediatric extended care center	**$500.00 per facility license.**
(i) ~~(h)~~ Subject to subsection (11), quality assurance assessment for nursing homes and hospital long-term care units	an amount resulting in not more than 6% of total industry revenues.

(j) ~~(i)~~ Subject to subsection (12), quality assurance assessment for hospitals		at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i).
(k) ~~(j)~~ Initial licensure application fee for subdivisions (a), (b), (c), (d), (e), (f), ~~and~~ (g)**, and (h)**		$2,000.00 per initial license.

(2) If a hospital requests the department to conduct a certification survey for purposes of title XVIII or title XIX, the hospital shall pay a license fee surcharge of $23.00 per bed. As used in this subsection:

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

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to 1396w-8.

(3) All of the following apply to the assessment under this section for certificates of need:

(a) The base fee for a certificate of need is $3,000.00 for each application. For a project requiring a projected capital expenditure of more than $500,000.00 but less than $4,000,000.00, an additional fee of $5,000.00 is added to the base fee. For a project requiring a projected capital expenditure of $4,000,000.00 or more but less than $10,000,000.00, an additional fee of $8,000.00 is added to the base fee. For a project requiring a projected capital expenditure of $10,000,000.00 or more, an

additional fee of $12,000.00 is added to the base fee.

(b) In addition to the fees under subdivision (a), the applicant shall pay $3,000.00 for any designated complex project including a project scheduled for comparative review or for a consolidated licensed health facility application for acquisition or replacement.

(c) If required by the department, the applicant shall pay $1,000.00 for a certificate of need application that receives expedited processing at the request of the applicant.

(d) The department shall charge a fee of $500.00 to review any letter of intent requesting or resulting in a waiver from certificate of need review and any amendment request to an approved certificate of need.

(e) A health facility or agency that offers certificate of need covered clinical services shall pay $100.00 for each certificate of need approved covered clinical service as part of the certificate of need annual survey at the time of submission of the survey data.

(f) Except as otherwise provided in this section, the department shall use the fees collected under this subsection only to fund the certificate of need program. Funds remaining in the certificate of need program at the end of the fiscal year do not lapse to the general fund but remain available to fund the certificate of need program in subsequent years.

(4) A license issued under this part is effective for no longer than 1 year after the date of issuance.

(5) Fees described in this section are payable to the department at the time an application for a license, permit, or certificate is submitted. If an application for a license, permit,

or certificate is denied or if a license, permit, or certificate is revoked before its expiration date, the department shall not refund fees paid to the department.

(6) The fee for a provisional license or temporary permit is the same as for a license. A license may be issued at the expiration date of a temporary permit without an additional fee for the balance of the period for which the fee was paid if the requirements for licensure are met.

(7) The cost of licensure activities must be supported by license fees.

(8) The application fee for a waiver under section 21564 is $200.00 plus $40.00 per hour for the professional services and travel expenses directly related to processing the application. The travel expenses must be calculated in accordance with the state standardized travel regulations of the department of technology, management, and budget in effect at the time of the travel.

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

(10) Except as otherwise provided in this section, the fees and assessments collected under this section must be deposited in the state treasury, to the credit of the general fund. The department may use the unreserved fund balance in fees and assessments for the criminal history check program required under this article.

(11) The quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** and all federal matching funds attributed to that assessment must be used only for the following purposes and under the following specific circumstances:

(a) The quality assurance assessment and all federal matching

funds attributed to that assessment must be used to finance Medicaid nursing home reimbursement payments. Only licensed nursing homes and hospital long-term care units that are assessed the quality assurance assessment and participate in the Medicaid program are eligible for increased per diem Medicaid reimbursement rates under this subdivision. A nursing home or long-term care unit that is assessed the quality assurance assessment and that does not pay the assessment required under subsection ~~(1)(h)~~ **(1)(i)** in accordance with subdivision (c)(*i*) or in accordance with a written payment agreement with this state shall not receive the increased per diem Medicaid reimbursement rates under this subdivision until all of its outstanding quality assurance assessments and any penalties assessed under subdivision (f) have been paid in full. This subdivision does not authorize or require the department to overspend tax revenue in violation of the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

(b) Except as otherwise provided under subdivision (c), beginning October 1, 2005, the quality assurance assessment is based on the total number of patient days of care each nursing home and hospital long-term care unit provided to non-Medicare patients within the immediately preceding year, must be assessed at a uniform rate on October 1, 2005 and subsequently on October 1 of each following year, and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed.

(c) Within 30 days after September 30, 2005, the department shall submit an application to the Centers for Medicare and Medicaid Services to request a waiver according to 42 CFR 433.68(e) to implement this subdivision as follows:

(*i*) If the waiver is approved, the quality assurance assessment rate for a nursing home or hospital long-term care unit with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application is $2.00 per non-Medicare patient day of care provided within the immediately preceding year or a rate as otherwise altered on the application for the waiver to obtain federal approval. If the waiver is approved, for all other nursing homes and long-term care units the quality assurance assessment rate is to be calculated by dividing the total statewide maximum allowable assessment permitted under subsection ~~(1)(h)~~ **(1)(i)** less the total amount to be paid by the nursing homes and long-term care units with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application by the total number of non-Medicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39 licensed beds, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, must be assessed in the first quarter after federal approval of the waiver and must be subsequently assessed on October 1 of each following year, and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed.

(*ii*) If the waiver is approved, continuing care retirement centers are exempt from the quality assurance assessment if the continuing care retirement center requires each center resident to provide an initial life interest payment of $150,000.00, on average, per resident to ensure payment for that resident's

residency and services and the continuing care retirement center utilizes all of the initial life interest payment before the resident becomes eligible for medical assistance under the state's Medicaid plan. As used in this subparagraph, "continuing care retirement center" means a nursing care facility that provides independent living services, assisted living services, and nursing care and medical treatment services, in a campus-like setting that has shared facilities or common areas, or both.

(d) Beginning May 10, 2002, the department shall increase the per diem nursing home Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the Medicaid nursing home reimbursement payment increase financed by the quality assurance assessment.

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

(f) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection ~~(1)(h),~~ **(1)(i)**, the department may assess the nursing home or hospital long-term care unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(g) The Medicaid nursing home quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment

with the state treasurer for deposit in the Medicaid nursing home quality assurance assessment fund.

(h) The department shall not implement this subsection in a manner that conflicts with 42 USC 1396b(w).

(i) The quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** must be prorated on a quarterly basis for any licensed beds added to or subtracted from a nursing home or hospital long-term care unit since the immediately preceding July 1. Any adjustments in payments are due on the next quarterly installment due date.

(j) In each fiscal year governed by this subsection, Medicaid reimbursement rates must not be reduced below the Medicaid reimbursement rates in effect on April 1, 2002 as a direct result of the quality assurance assessment collected under subsection ~~(1)(h).~~**(1)(i).**

(k) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** must be equal to 13.2% of the federal funds generated by the nursing homes and hospital long-term care units quality assurance assessment, including the state retention amount. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for long-term care services. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2027, the department shall not assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not

eligible for federal matching funds. Any portion of the quality assurance assessment collected from a nursing home or hospital long-term care unit that is not eligible for federal matching funds must be returned to the nursing home or hospital long-term care unit.

(12) The quality assurance dedication is an earmarked assessment collected under subsection ~~(1)(i).~~ **(1)(j).** That assessment and all federal matching funds attributed to that assessment must be used only for the following purpose and under the following specific circumstances:

(a) To maintain the increased Medicaid reimbursement rate increases as provided for in subdivision (c).

(b) The quality assurance assessment must be assessed on all net patient revenue, before deduction of expenses, less Medicare net revenue, as reported in the most recently available Medicare cost report and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed. As used in this subdivision, "Medicare net revenue" includes Medicare payments and amounts collected for coinsurance and deductibles.

(c) Beginning October 1, 2002, the department shall increase the hospital Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the hospital Medicaid reimbursement rate increase financed by the quality assurance assessments.

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

(e) If a hospital fails to pay the assessment required by subsection ~~(1)(i),~~ **(1)(j),** the department may assess the hospital a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(f) The hospital quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the hospital quality assurance assessment fund.

(g) In each fiscal year governed by this subsection, the quality assurance assessment must only be collected and expended if Medicaid hospital inpatient DRG and outpatient reimbursement rates and graduate medical education payments are not below the level of rates and payments in effect on April 1, 2002 as a direct result of the quality assurance assessment collected under subsection ~~(1)(i),~~ **(1)(j),** except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection ~~(1)(i)~~ **(1)(j)** must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds must be returned to the hospital.

(i) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(i)~~ **(1)(j)** must be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The

13.2% state retention amount described in this subdivision does not apply to the Healthy Michigan plan. Beginning in the fiscal year ending September 30, 2018, and for each fiscal year thereafter, there is a retention amount of at least $118,420,600.00 for each fiscal year for the Healthy Michigan plan. By May 31 of each year, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount for the Healthy Michigan plan. The state retention percentage must be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

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

(a) The quality assurance assessment authorized under this subsection must be used to provide reimbursement to Medicaid ambulance providers. The department may promulgate rules to provide the structure of the quality assurance assessment authorized under this subsection and the level of the assessment.

(b) The department shall implement this subsection in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(c) The total annual collections by the department under this subsection must not exceed $20,000,000.00.

(d) The quality assurance assessment authorized under this

subsection must not be collected after October 1, 2027. The quality assurance assessment authorized under this subsection must no longer be collected or assessed if the quality assurance assessment authorized under this subsection is not eligible for federal matching funds.

(e) By November 1 of each year, the department shall send a notification to each ambulance operation that will be assessed the quality assurance assessment authorized under this subsection during the year in which the notification is sent.

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

(15) As used in this section:

(a) "Healthy Michigan plan" means the medical assistance program described in section 105d of the social welfare act, 1939 PA 280, MCL 400.105d, that has a federal matching fund rate of not less than 90%.

(b) "Medicaid" means that term as defined in section 22207.

PART 219A

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

Sec. 21951. (1) As used in this part:

(a) "Basic service" includes, but is not limited to, both of the following:

(*i*) Developing, implementing, and monitoring a comprehensive protocol of care for a patient that meets the requirements described in section 21965.

(*ii*) The caregiver training needs to the extent it is for the parent or guardian of a patient.

(b) "Center administrator" means the center administrator of the prescribed pediatric extended care center who is designated

under section 21955.

(c) "Child with medical complexity" means an individual who is under the age of 22 with medical complexity. A child with medical complexity does not include an individual if the individual has a severe and persistent mental health disorder.

(d) "Contracted or supportive service" includes, but is not limited to, speech therapy, occupational therapy, physical therapy, social work services, developmental services, child life services, and psychology services.

(e) "Direct care" means education, social services, or child care.

(f) "Medical complexity" means a condition or disability that meets all of the following requirements:

(*i*) Is acute, chronic, or intermittent.

(*ii*) Requires ongoing, physician prescribed, skilled nursing care to avert death or further disability.

(*iii*) Requires the use of a medical device to compensate for a deficit in a life-sustaining body function.

(*iv*) Requires continuous nursing care.

(g) "Medical director" means the medical director of the prescribed pediatric extended care center who meets the requirements of section 21959.

(h) "Nursing director" means the nursing director of the prescribed pediatric extended care center who meets the requirements of section 21959.

(i) "Patient" means a child with medical complexity who receives a basic service in a prescribed pediatric extended care center.

(j) "Prescribed pediatric extended care center" or "center"

means a facility, other than a hospital or nursing home, that provides a basic service in a nonresidential setting to 3 or more individuals, each of whom is a child with medical complexity.

(2) In addition, article 1 contains general definitions and principles of construction applicable to all articles in this code, and part 201 contains definitions applicable to this part.

Sec. 21953. Beginning October 1, 2026, all of the following apply:

(a) A prescribed pediatric extended care center must be licensed under this article.

(b) "Prescribed pediatric extended care center" or "p.p.e.c. center" must not be used to describe or refer to a health facility unless the health facility is licensed as a prescribed pediatric extended care center by the department under this article.

Sec. 21955. The owner, operator, and governing body of a prescribed pediatric extended care center licensed under this article:

(a) Are responsible for all phases of the operation of the prescribed pediatric extended care center and quality of care rendered in the prescribed pediatric extended care center.

(b) Shall cooperate with the department in the enforcement of this article and require that a physician and other individuals working in the prescribed pediatric extended care center and for whom a license or registration is required are currently licensed or registered.

(c) Shall designate 1 individual to act as the center administrator.

Sec. 21957. The center administrator is responsible for the overall management of the prescribed pediatric extended care

center. The center administrator shall do all of the following:

(a) Designate in writing an individual who is responsible for the prescribed pediatric extended care center when the center administrator is absent from the prescribed pediatric extended care center for more than 24 hours.

(b) Maintain all of the following written records and make them available to the department for inspection on the department's request:

(*i*) A daily census record that includes the number of patients currently receiving a basic service at the prescribed pediatric extended care center.

(*ii*) A record of each accident or unusual incident involving a patient or employee of the prescribed pediatric extended care center that caused, or had the potential to cause, injury or harm to an individual at the prescribed pediatric extended care center or to property of the prescribed pediatric extended care center.

(*iii*) A copy of each agreement with a provider of a contracted or supportive service at the prescribed pediatric extended care center.

(*iv*) A copy of each agreement with a consultant who is employed by the prescribed pediatric extended care center and documentation of each of the consultant's visits.

(*v*) A personnel record for each employee of the prescribed pediatric extended care center that includes the employee's application for employment, references, employment history for the 5 years immediately preceding the date of application for employment, and a copy of each performance evaluation for the employee.

(c) Develop and maintain a current job description for each

employee of the prescribed pediatric extended care center.

(d) Provide necessary qualified employees and ancillary services to ensure the health, safety, and proper care for each patient at the prescribed pediatric extended care center.

(e) Develop and implement an infection control policy that complies with any rules promulgated by the department.

Sec. 21959. (1) The department shall not grant a license to a prescribed pediatric extended care center under this part unless the prescribed pediatric extended care center has all of the following on its staff:

(a) A medical director who is a physician licensed under article 15 and who is board certified in pediatrics.

(b) A nursing director who is responsible for the daily operation of the prescribed pediatric extended care center. The nursing director must meet all of the following requirements:

(*i*) Be a registered professional nurse licensed under article 15.

(*ii*) Be certified in basic life support.

(*iii*) At the time of hire, have not less than 2 years of nursing experience within the previous 6 years, at least 1 year of which was spent in a pediatric intensive care unit or neonatal intensive care setting.

(2) Except for the nursing director described in subsection (1), a registered professional nurse who is employed by a prescribed pediatric extended care center must be licensed under article 15, be certified in basic life support, and meet 1 of the following requirements:

(a) At the time of hire, have not less than 2 years of nursing experience within the previous 6 years, at least 1 year of which

was spent in a pediatric intensive care unit or neonatal intensive care setting.

(b) Have successfully completed a training program that meets all of the following requirements:

(*i*) The training program demonstrates sufficient skills for the responsibilities of a registered professional nurse in a prescribed pediatric extended care center.

(*ii*) The training program is considered appropriate by the center administrator, the medical director, and the nursing director.

(*iii*) The training program is outlined in a written policy of the prescribed pediatric extended care center.

(3) A licensed practical nurse who is employed by a prescribed pediatric extended care center must be licensed under article 15, be certified in basic life support, and meet 1 of the following requirements:

(a) At the time of hire, have not less than 2 years of nursing experience within the previous 6 years, at least 1 year of which was spent in a pediatric intensive care unit or neonatal intensive care setting.

(b) Have successfully completed a training program that meets all of the following requirements:

(*i*) The training program demonstrates sufficient skills for the responsibilities of a licensed practical nurse in a prescribed pediatric extended care center.

(*ii*) The training program is considered appropriate by the center administrator, the medical director, and the nursing director.

(*iii*) The training program is outlined in a written policy of

the prescribed pediatric extended care center.

(4) An individual providing direct care who is employed by a prescribed pediatric extended care center must work under the supervision of a registered professional nurse meeting the requirements described in subsection (2). An individual providing direct care to a patient at a prescribed pediatric extended care center must be certified in basic life support and meet 1 of the following requirements:

(a) Have extensive, documented education and training in providing direct care to infants and toddlers and provide employment references documenting skill in the direct care of infants and toddlers.

(b) Have successfully completed a training program that meets all of the following requirements:

(*i*) The training program demonstrates sufficient skills for individuals providing direct care in a prescribed pediatric extended care center.

(*ii*) The training program is considered appropriate by the center administrator, the medical director, and the nursing director.

(*iii*) The training program is outlined in a written policy of the prescribed pediatric extended care center.

Sec. 21961. (1) A prescribed pediatric extended care center shall develop and maintain a staffing plan for nursing services and direct care at the prescribed pediatric extended care center. The staffing plan must require not less than 2 registered professional nurses and not less than 1 nurse aide registered under part 219, and must meet the following additional staffing requirements, as applicable:

(a) For a center with 3 to 12 patients, 2 registered professional nurses and 2 additional staff who are nurse aides registered under part 219 or are health professionals with education and training that is greater than that of a nurse aide.

(b) For a center with 13 to 18 patients, 2 registered professional nurses, 1 licensed practical nurse, and 3 individuals providing direct care to patients.

(c) For a center with 19 to 24 patients, 2 registered professional nurses, 2 licensed practical nurses, and 4 individuals providing direct care to patients.

(d) For a center with 25 to 30 patients, 3 registered professional nurses, 3 licensed practical nurses, and 5 individuals providing direct care to patients.

(e) For a center with 31 to 36 patients, 4 registered professional nurses, 4 licensed practical nurses, and 6 individuals providing direct care to patients.

(f) For a center with 37 to 42 patients, 5 registered professional nurses, 5 licensed practical nurses, and 7 individuals providing direct care to patients.

(g) For a center with more than 43 patients, the number of registered professional nurses, licensed practical nurses, and direct staff described in subdivision (f) is increased by 1 for each qualified increase. As used in this subdivision, "qualified increase" means increase of patients by not less than 1 to not more than 6.

(2) The staffing plan required under this section must be in writing, be updated and disclosed quarterly, and be available to the employees of the prescribed pediatric extended care center and the public for inspection on request.

Sec. 21962. (1) A prescribed pediatric extended care center shall comply with all of the following:

(a) Subject to subsection (2), conduct monthly staff development programs to maintain quality patient care. A staff development program must be appropriate to the category of employee attending the program and must be documented by the prescribed pediatric extended care center.

(b) Ensure that an employee maintains certification in basic life support.

(c) Ensure that a new employee participates in an orientation to acquaint the employee with the philosophy, organization, program, practices, and goals of the prescribed pediatric extended care center.

(d) Ensure that a parent or guardian of a child with medical complexity attends a comprehensive orientation to acquaint the parent or guardian with the philosophy and services provided to a child with medical complexity in the prescribed pediatric extended care center.

(e) Provide training to an employee when implementing new technology.

(f) Ensure that a patient is admitted to the center for not more than 12 consecutive hours per day.

(g) Ensure that patients receive basic services only during standard, daytime working hours, as established by the center.

(2) A staff development program required under this section must do all of the following:

(a) Facilitate the ability of an employee to function as a member of an interdisciplinary team with other health professionals and a parent or guardian of a child with medical complexity.

(b) Improve the communication skills of an employee to facilitate a collaborative relationship with a parent or guardian of a patient.

(c) Increase employee understanding of how to cope with the effects of childhood illness.

(d) Cover all of the following topics:

(*i*) Issues related to death and dying.

(*ii*) Information on services that the prescribed pediatric extended care center considers appropriate that are available from hospitals, schools, and community, state, and professional organizations.

(e) Foster advocacy skills and develop case management skills to assist a parent or guardian of a patient with setting priorities and planning and implementing the patient's care at home.

Sec. 21963. (1) A prescribed pediatric extended care center shall perform a functional assessment of a patient and create an individualized program plan for the patient to accommodate the patient's developmental needs.

(2) The functional assessment required under this section must assess all of the following for a patient, considering the patient's age:

(a) Self-care.

(b) Communication, social, and motor skills.

(c) Cognitive function.

(d) Play.

(e) Growth and development.

(3) The individualized program plan required under this section must be in writing and include all of the following for a patient:

(a) Specific programs and actions to facilitate the developmental progress of the patient.

(b) Measurable goals for each need area.

(c) The patient's strengths and present performance level with respect to each goal described in subdivision (b).

(d) Anticipatory planning for specific areas identified as at risk for future problems.

(4) The prescribed pediatric extended care center shall include a parent or guardian of a patient in a care-related conference for the patient and, if applicable, facilitate the training of the parent or guardian on how to meet the developmental and psychosocial needs of the patient while the patient is at home.

Sec. 21965. (1) Subject to this section, a prescribed pediatric extended care center shall have a written policy governing the admission, transfer, and discharge of a child with medical complexity.

(2) After consulting with the parent or guardian of a child with medical complexity, a physician may refer the child with medical complexity to a prescribed pediatric extended care center. A child with medical complexity must not be admitted to a prescribed pediatric extended care center unless at least all of the following are met:

(a) Before admission, it is determined that the child with medical complexity does not present a significant risk of infection to other children or employees in the prescribed pediatric extended care center. The medical director and nursing director shall review a child with medical complexity who is suspected of having an infectious disease to determine whether the admission of the child with medical complexity to the prescribed pediatric extended care

center is appropriate.

(b) The child with medical complexity is medically stable, requires skilled nursing care or other intervention, and has a clinical condition that is appropriate for outpatient care.

(c) The admission of the child with medical complexity is in accordance with a written order of a physician. A copy of the order must be provided to the parent or guardian of the child with medical complexity and must be placed in the child's medical record.

(3) If a child with medical complexity meets the requirements described in subsection (2), the medical director or nursing director shall implement a preadmission plan. The preadmission plan must describe the services to be provided to the child with medical complexity in the prescribed pediatric extended care center and the sources for the services. If the child with medical complexity is hospitalized at the time of the referral to the prescribed pediatric extended care center, the development of the preadmission plan must include the parent or guardian of the child with medical complexity, a representative of the prescribed pediatric extended care center, and hospital medical, nursing, social services, and developmental staff, to ensure that the hospital's discharge plans are implemented upon the admission of the child with medical complexity to the prescribed pediatric extended care center. If the child with medical complexity is not hospitalized at the time of the referral to the prescribed pediatric extended care center, the development of the preadmission plan must include the parent or guardian of the child with medical complexity, the child with medical complexity's primary care provider, a representative of the prescribed pediatric extended care center, and representatives of

other agencies that the child with medical complexity's primary care provider and nursing director consider relevant.

(4) During the development of a preadmission plan for a child with medical complexity, a protocol of care for the child with medical complexity must be developed under the direction of the nursing director. The protocol of care must be in writing and must include all of the following:

(a) The treatment plan that addresses the medical, nursing, psychosocial, and educational needs of the child with medical complexity and the family of the child with medical complexity.

(b) The specific goals for the care of the child with medical complexity, including the plans for achieving the goals.

(c) A schedule for evaluating the progress of the child with medical complexity.

(d) The procedures to follow during an emergency.

(e) The criteria for discharging the child with medical complexity from the prescribed pediatric extended care center.

(f) The signature of the provider, a representative of the prescribed pediatric care center, and the parent or guardian of the child with medical complexity.

(5) A prescribed pediatric extended care center must require a parent or guardian of a child with medical complexity to sign a consent form before the admission of the child with medical complexity to the center. The prescribed pediatric extended care center must provide the parent or guardian of the child with medical complexity with a copy of the signed consent form. The consent form is confidential and must include at least all of the following:

(a) The purpose of the prescribed pediatric extended care

center.

(b) The responsibilities of the family of a child with medical complexity.

(c) The treatment authorized for the child with medical complexity.

(d) Emergency disposition plans.

(e) A space for the signature of the parent or guardian signing the form and a space for the signature of 1 or more witnesses to the signature of the parent or guardian.

Sec. 21967. A prescribed pediatric extended care center shall provide or arrange for the transportation of a patient to and from the prescribed pediatric extended care center unless the parent or guardian of the patient chooses to provide for the patient's own transportation. If the prescribed pediatric extended care center transports a patient to or from the prescribed pediatric extended care center, the prescribed pediatric extended care center is responsible for the safety of the patient during transport.

Sec. 21968. A prescribed pediatric extended care center shall adopt and enforce a written policy that contains procedures to ensure that the center submits accurate transportation billing and insurance claims.

Sec. 21969. In addition to the requirements under section 20175 and 20175a, a prescribed pediatric extended care center shall keep and maintain a record for each patient. The record must include the name, title, and signature of each individual making an entry into the record for a patient and include all of the following:

(a) Provider orders.

(b) Flow charts of medications and treatments administered.

(c) Concise and accurate information and initiated case notes reflecting progress toward achieving protocol of care goals or reasons for a lack of progress.

(d) Documentation of nutritional management and special diets, as appropriate.

(e) Documentation of nursing, goals, treatment plans, and documentation of each treatment, including the date and time that each treatment is provided to the patient and the patient's progress.

(f) Documentation of social and developmental services, including the date and time that each service is provided to the patient and the patient's progress.

(g) Any allergies of the patient or special precautions.

(h) The patient's immunization record.

(i) Any revisions or recommended changes to the patient's therapeutic plan in the individualized protocol of care developed for the child with medical complexity under section 21965.

(j) Any discharge order for the child with medical complexity. The discharge order must be signed by a physician and must include a discharge summary that includes the reason for discharge.

(k) A signed copy of the consent form described in section 21965.

Sec. 21971. A prescribed pediatric extended care center shall implement a quality assurance program to evaluate the provision of care within the prescribed pediatric extended care center. The quality assurance program must include the participation of the medical director and include all of the following evaluations:

(a) At least every 6 months, an evaluation of each organized service that relates to patient care, including, but not limited

to, a service furnished by a contractor.

(b) At least every 6 months, an evaluation of the evidence of the involvement of a parent or guardian of a patient.

(c) The evaluation of nosocomial infections and medication therapy.

(d) Quarterly evaluations of staffing plans developed under section 21961 to ensure staffing standards are met and to improve regulatory efficiency.