ADMINISTRATIVE RULES FOR SUBSTANCE USE DISORDER SERVICE PROGRAMS, PUBLIC HEARING

August 31, 2022

Prepared by

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STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

BUREAU OF COMMUNITY AND HEALTH SYSTEMS

RE: ADMINISTRATIVE RULES
FOR SUBSTANCE USE DISORDER
SERVICE PROGRAMS,
RULE SET 2021-90 LR
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PUBLIC HEARING

Lansing, Michigan - Wednesday, August 31, 2022

APPEARANCES:

On Behalf of the Department of Licensing and Regulatory Affairs:	MS. TAMMY BAGBY MR. MATT JORDAN Bureau of Community & Health Systems P.O. Box 30664 Lansing, Michigan 48909
Recorded By:	Karen L. Banks, CER 3592 Certified Electronic Recorder Network Reporting Corporation Firm Registration Number 8151 1-800-632-2720

Lansing, Michigan

Wednesday, August 31, 2022 - 9:01 a.m.

MS. BAGBY: Good morning. My name is Tammy Bagby and I am an analyst in the Bureau of Community and Health Systems in the Department of Licensing and Regulatory Affairs.

This hearing regarding the Administrative Rules for Substance Use Disorder Programs is being called to order at 9:01 on August 31st at the G. Mennen Williams Building auditorium located at 525 West Ottawa Street in Lansing, Michigan. The hearing is being conducted under the authority of the Administrative Procedures Act, P.A. 306 of 1969.

The notice of public hearing was published in three newspapers of general circulation, as well as the Michigan Register published on August 15, 2022.

Regulatory Impact Statement copies are available in the hall where you came in, for further explanation of these rule sets. They can also be found on the website for the Michigan Office of Administrative Hearings and Rules.

Pursuant to section 45 of the Administrative Procedures Act, the public hearing is an opportunity for the public to present data, views, questions and arguments regarding the proposed rules.

The Department will use the testimony and documents presented at this hearing to determine if any changes should be made to the proposed rules before they are adopted. If you

have comments, please make sure they relate directly to the proposed rules. If you have questions regarding the rules, please submit your questions as part of your testimony for the Department's review. If you have suggested changes to the proposed rules, please include the specific reasons why the changes would be in the public interest.

If you wish to comment, complete a white card, available when you came in. This will help the Department prepare the hearing record. When you testify, please identify yourself by name and organization, if any, that you may be speaking for.

Written statements can be submitted directly to me. The Department will also accept written statements e-mailed or postmarked until 5 p.m. on today, August 31st. Additional information can be found in the notice of the public hearing that we have made available in the hall.

If you wish to testify and have not completed a card, you can grab one from the hallway.

The Department staff from the Bureau of Community and Health Systems include myself; Larry Horvath, Director of the Bureau of Community and Health Systems; Matt Jordan, Jim Hoyt, and Kelly Moore from the Non-Long-Term Care State Licensing Program.

Before we start the public comments, I invite Matt Jordan to the podium.

MR. JORDAN: Good morning. Thank you for coming today. My name is Matt Jordan. I'm the manager for the Non-Long-Term Care State Licensing Section, which includes oversight of the substance use disorder licensed programs.

Today I'm going to touch briefly on the SUD rule changes that are going to occur. This is just a broad overview. It's not exclusive -- or inclusive of every change in there, but these are the significant points within these rules. This is the first rule change since the December 2018 previous administrative rule change for substance use disorder programs.

To begin, these rules proposed will:

Clarify that licensure is not required inside local, state or federal facilities such as correctional institutions;

Eliminates licensure for screening, Buprenorphine and Naltrexone programs by rule change;

Eliminates rule requirements for prevention and for hospitals that will require legislation to deregulate unlike the previous-mentioned Buprenorphine and Naltrexone screening;

Will create branch offices for outpatient services, allowing for a single license to serve a larger market;

Will create mobile services, allowing for a single license to serve a larger market area;

Requires Naloxone policy and procedure to assure access;

Clarifies training requirements for staffing;

Adds additional licensed professionals that can provide substance use disorder counseling services, such as marriage and family therapists;

Adds an additional certified professional that can provide substance use disorder counseling services, the limited certified counselor with a limited recipient ratio;

Creates new service categories for residential detoxification programs to include clinically managed and medically monitored withdrawal management service categories;

And finally, aligns screening and take-home treatment schedules for Methadone programs with the federal standards.

MS. BAGBY: Great. We will now begin the public comment time frame. Do we have any other white cards? Anybody else that would like to speak before we start? No? Okay.

The first person that I have is Dave Blankenship. Please come to the microphone and remember to state your name and who you are with.

MR. BLANKENSHIP: Good morning. My name is David Blankenship. I'm representing Michigan Association for Treatment of Opioid Dependence and Victory Clinical Services.

I'd like by saying I appreciate the rule changes. I think they're going to help the outpatient Methadone programs

significantly following the 42 C.F.R. Part A, so I really appreciate that.

There were a couple concerns that I wanted to address. The main one is R-325.1381, which talks about the limited certified counselor, and the question that I have, the ratio of 32 consumers, patients that they can counsel, it takes almost three years to get that, the CADC through MBCAP. So my question was, is there any chance to modify that to maybe 50-to-one or potentially look at progressing it from 32-to-one for maybe six months to a year, and then allow 50 to one patient. That's it. Thank you.

MS. BAGBY: Thank you, David.

The next card I have is -- Peter, did you want to speak? How do you pronounce your last name?

MR. BUCCI: "BOO-chee" (ph.).

MS. BAGBY: "BOO-chee."

MR. BUCCI: Like Gucci, but with a "B."

MS. BAGBY: Gotcha. We were going with "Bocci" earlier.

MR. BUCCI: My name is Peter Bucci. I'm the executive director of Harbor Hall. It's nice to see everybody. Thank you for the opportunity.

My only critique or something that I would like to see within the rule change is some specifics on that limited certified counselor, what exactly that entails, and then, you

know, what the credential -- or what the marker would be to meet that particular credential. It seems a little broad, a little vague.

And preferably, at least on my end as far as the new clinicians and new employees coming in, some of their training seems to be a little lax or a little sped up in their particular programming, and so if the test itself was that reliable and valid source to indicate that they have met the markers necessary to provide these professional services, I think that would be a very smooth process. Whether it's a year thing or a C.E. thing, that can all be sort of sped along a little quicker than it should be, and so at least the test would be something that they'd actually have to prepare for and it could be valid. So, thank you.

MS. BAGBY: Thank you, Peter.

Does anybody else have any public comment at this time? Okay.

MR. PRICE: Sam Price. I'm the CEO for Ten16 Recovery Network, as well as representing the SUD Contingent Other Provider Alliance, and we've already submitted our written comments, but the particular ones we'd want to emphasize would again be related to some of the open areas related to the limited certified counselor in terms of understanding what it takes to get that status. We know part of that's a coordination with MBCAP, but it gets into

significant employment issues for us as providers if we don't know how we can get compensated for the services that they may be eligible for until they can secure that distinction.

And as David was talking about in terms of the limited caseload, we don't have -- see the same kind of limitations for somebody with a limited license in social work or a limited license in professional counseling. So why is there a specific reduction in caseload being applied to these individuals who may have a four-year degree -- may not. So we understand some of those things.

The other thing that we would particularly want to highlight would be questions regarding the clinically managed withdrawal management program, particularly in three areas. Well, one specific to the clinically one is the statement about not being able to offer, administer controlled substances. Really what we're looking for is clarification of how that would be interpreted and applied. For example, the CARF policies, ASAM policies in the Michigan Medicaid manual all allow for some programs to monitor self-administration of prescriptions that have been prescribed and dispensed to an individual by a physician. So if a program that is clinically managed could do monitoring of self-administration, then there's no concern about the language. But it really is a lot of interpretation and application and enforcement

The other two, I think, go to all of the withdrawal

management programs in terms of there is reference about being seen by a physician upon admission and medications not being started until seen by a physician at admission, and that, just for even a medically monitored program, a doctor is not necessarily on site 24/7 to be able to do those kinds of things. So to withhold medications until they can see the physician can be quite problematic and really quite -- create a risky situation for that particular recipient.

And then one little caveat from some of my friends in the U.P. specific to the satellite language. When they're working in frontier counties, they were wondering if a branch office could be up to a hundred miles, because in some of those remote communities they have to go even further distances in order to be available a day or two a week for, you know, people in those counties.

So again, it's all captured in our written ones, but we wanted to bring it to your attention again today. Thank you.

MS. BAGBY: Thank you, Sam. We did receive your written comments.

The next person I have is Lucila Ryder.

MS. RYDER: Good morning. My name is Lucila Ryder. I'm from Star Center, located in Detroit, and I'm also with the Michigan Association --

(Drops microphone)

MS. RYDER: For my next act --

(Laughter)

MS. RYDER: I am also with the Michigan Association for the Treatment of Opioid Dependence.

I also wanted to address what my colleague David Blankenship referred to earlier in regards to the R-325.3381, number 6. I'm sure everybody's aware of the shortage that we have in professional staff and in the field of social work, and it's very, very difficult for us throughout the state of Michigan to find the correct staff that we need to service our patients that we have. That's why we really would like to enforce the people that are interested in becoming certified addiction counselors to increase their load past the thirty mark. It would provide better training for them, it would give patients -- more patients access to treatment, and financially it would make better sense.

If you have someone who is servicing only thirty patients, that would possibly be just a part-time job for them, and how do they go where they're having a part-time job? We could spend more time educating them and helping them to be better professionals in our field. Again, we are having an extreme emergency in our field getting licensed Masters of Social Work, Masters of Social Work, Bachelors of Social Work. Very, very difficult to find the professionals that we need. Thank you for all your time and all your efforts.

MS. BAGBY: Thank you for your comments.

The next person we have -- and I apologize -- Kanzoni Asabigi. Is that even close?

MR. ASABIGI: Kanzoni Asabigi.

MS. BAGBY: Got that.

MR. ASABIGI: Good morning. My name is Kanzoni Asabigi from the Detroit Recovery Project in the city of Detroit, and also representing the Detroit/Wayne County Association of Substance Addiction Professionals.

I just wanted to make a comment in support of the revisions proposed, and especially for those individuals that are receiving MAT treatment, especially Methadone, and also just making sure that these individuals continue to get the treatment that they need. So eliminating the rule whereby people are discharged, it's a good one, because we want to continue to get people into treatment. You know, they're sick, so if they are non-compliant, that's not a reason to get them out of treatment, you know. So as long as they are engaged in that, receiving services, I think that's a good thing to do.

And also, you know, the mobile unit provision allowing for those that have already been licensed, you know, to continue to provide the service, I think it's a good one instead of creating another barrier for them for mobile units to get a separate number or license, you know, to provide that

service. One of the things that we providers must do to make sure that people are not moving from one provider to another, you know, getting double doses or potential overdose, and just to make sure we work together to make sure that we provide the services to the individuals that need it. Thank you.

MS. BAGBY: Thank you for your comments.

Next we have Deidre Goldsmith. Welcome.

MS. GOLDSMITH: Good morning.

Hi, I'm Deirdre Goldsmith with Therapeutics. So I'm referring to the limited counselor. We've tried the scheduling for the limited counselor, and I wonder first of all where they got the cap, because I understand that these are counselors in training, but they need the hours to get their training, and scheduling them for 32 or 35 clients is not enough for them to get the training. There are a lot of gaps in their schedules, and as Ms. Ryder said, it's like a part-time job. So I'd kind of like to know where they arrived at these figures, because it's very, very difficult to train people, pay people, and get the patients seen because they're not considering the breakage. A lot of people, they'll cancel appointments, won't show up, and if they're limited in their caseloads, can we have someone from another caseload to see them or -- you know, it's limiting us. Thank you.

MS. BAGBY: Thank you.

Do we have any other people that would like to

comment?

MR. RYDER: Hi. I'm Matthew Ryder from Star Center. Just one quick comment I have regarding the role with 32-to-one, the development plans. Employers are going to choose CADCs. You know, if they have a ton of applications in front of them and they see CADC or development plan, they're going to choose a CADC every time, knowing that they can have 65 patients. So that kind of also creates a barrier for those who have development plans to get the hours needed so that they become full-fledged CADCs. So I think that's another reason why they should be allowed more patients so that gives more development plans more opportunities with every employer. Thank you.

MS. BAGBY: Thank you, Matthew.

Do we have any other people that would like to comment? Okay. Not seeing any, we will take a ten-minute recess and come back at 9:30.

(Recess from 9:21 a.m. until 9:30 a.m.)

MS. BAGBY: We're officially back on the record now. It is 9:30.

Last call. Do we have anybody else that would like to submit comments?

MS. SHOCK: (indiscernible)

REPORTER: You have to come to the microphone.

MS. BAGBY: Okay. Yeah, yeah, just state your name

and we'll --

MS. SHOCK: I'm Dayna Shock. I'm from Mid-Michigan Community Health Services in Houghton Lake. I would like to put a little more attention on the satellite locations and potentially mobile units. Being in Houghton Lake in rural Michigan, we have a severe lack of insurance rides for patients. If patients are able to get scheduled, they are probably 95 percent of the time cancelled because they can't get a ride. So being able to branch off and have those satellite locations would provide an extreme opening for access of care to patients. I know we have patients that drive like hour-and-a-half, two hours to come and see us.

MS. BAGBY: Okay. Any other public comments? Seeing none, I would like to thank everybody for attending today and for your comments. Everything that we have received both today, verbally and written, will be reviewed and evaluated. And with that, I will close at 9:32. We're now off the record.

(Public hearing concluded at 9:32 a.m.)

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