

ADMINISTRATIVE RULES FOR SUBSTANCE
USE DISORDER SERVICE PROGRAMS,
PUBLIC HEARING

August 31, 2022

Prepared by



depos@networkreporting.com

Phone: 800.632.2720

Fax: 800.968.8653

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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
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1 Lansing, Michigan

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

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

6 This hearing regarding the Administrative Rules for
7 Substance Use Disorder Programs is being called to order at
8 9:01 on August 31st at the G. Mennen Williams Building
9 auditorium located at 525 West Ottawa Street in Lansing,
10 Michigan. The hearing is being conducted under the authority
11 of the Administrative Procedures Act, P.A. 306 of 1969.

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

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

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

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

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

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

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

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

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

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

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

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

12 To begin, these rules proposed will:

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

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

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

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

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

24 Requires Naloxone policy and procedure to assure
25 access;

1 Clarifies training requirements for staffing;

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

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

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

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

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

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

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

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

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

3 There were a couple concerns that I wanted to
4 address. The main one is R-325.1381, which talks about the
5 limited certified counselor, and the question that I have, the
6 ratio of 32 consumers, patients that they can counsel, it
7 takes almost three years to get that, the CADC through MBCAP.
8 So my question was, is there any chance to modify that to
9 maybe 50-to-one or potentially look at progressing it from
10 32-to-one for maybe six months to a year, and then allow 50 to
11 one patient. That's it. Thank you.

12 MS. BAGBY: Thank you, David.

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

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

16 MS. BAGBY: "BOO-chee."

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

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

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

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

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

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

15 MS. BAGBY: Thank you, Peter.

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

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

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

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

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

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

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

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

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

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

21 The next person I have is Lucila Ryder.

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

25 (Drops microphone)

1 MS. RYDER: For my next act --

2 (Laughter)

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

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

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

1 MS. BAGBY: Thank you for your comments.

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

4 MR. ASABIGI: Kanzoni Asabigi.

5 MS. BAGBY: Got that.

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

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

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

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

6 MS. BAGBY: Thank you for your comments.

7 Next we have Deidre Goldsmith. Welcome.

8 MS. GOLDSMITH: Good morning.

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

24 MS. BAGBY: Thank you.

25 Do we have any other people that would like to

1 comment?

2 MR. RYDER: Hi. I'm Matthew Ryder from Star Center.
3 Just one quick comment I have regarding the role with
4 32-to-one, the development plans. Employers are going to
5 choose CADCs. You know, if they have a ton of applications in
6 front of them and they see CADC or development plan, they're
7 going to choose a CADC every time, knowing that they can have
8 65 patients. So that kind of also creates a barrier for those
9 who have development plans to get the hours needed so that
10 they become full-fledged CADCs. So I think that's another
11 reason why they should be allowed more patients so that gives
12 more development plans more opportunities with every employer.
13 Thank you.

14 MS. BAGBY: Thank you, Matthew.

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

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

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

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

23 MS. SHOCK: (indiscernible)

24 REPORTER: You have to come to the microphone.

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

1 and we'll --

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

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

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

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<p style="text-align: center;">A</p> <p>a.m 2:2 13:18,18 14:19</p> <p>able 8:15 9:5 14:7,9</p> <p>accept 3:13</p> <p>access 4:25 10:15 14:11</p> <p>act 2:11,20 10:1</p> <p>addiction 10:13 11:9</p> <p>additional 3:14 5:2 5:5</p> <p>address 6:4 10:5</p> <p>Adds 5:2,5</p> <p>administer 8:15</p> <p>administrative 1:4 2:6,11,18,19 4:10</p> <p>admission 9:2,3</p> <p>adopted 2:25</p> <p>Affairs 1:2,14 2:5</p> <p>aligns 5:11</p> <p>Alliance 7:20</p> <p>allow 6:10 8:19</p> <p>allowed 13:11</p> <p>allowing 4:21,22 11:22</p> <p>analyst 2:4</p> <p>anybody 5:16 7:16 13:21</p> <p>apologize 11:3</p> <p>APPEARANCES 1:11</p> <p>application 8:24</p> <p>applications 13:5</p> <p>applied 8:8,17</p> <p>appointments 12:21</p> <p>appreciate 5:24 6:2</p> <p>area 4:23</p> <p>areas 7:22 8:13</p> <p>arguments 2:21</p> <p>arrived 12:17</p> <p>Asabigi 11:3,4,4,6,7</p> <p>ASAM 8:18</p> <p>Association 5:22 9:24 10:3 11:9</p> <p>assure 4:24</p> <p>attending 14:14</p> <p>attention 9:17 14:4</p> <p>auditorium 2:9</p> <p>August 1:9 2:2,8,14 3:14</p> <p>authority 2:10</p> <p>available 2:15 3:8</p>	<p>3:16 9:14</p> <p>aware 10:7</p> <hr/> <p style="text-align: center;">B</p> <p>B 6:17</p> <p>Bachelors 10:23</p> <p>back 13:17,19</p> <p>Bagby 1:12 2:3,3 5:14 6:12,16,18 7:15 9:19 11:1,5 12:6,24 13:14,19 13:25 14:13</p> <p>Banks 1:16</p> <p>barrier 11:24 13:8</p> <p>becoming 10:12</p> <p>Behalf 1:12</p> <p>better 10:14,16,21</p> <p>Blankenship 5:18 5:21,22 10:6</p> <p>Bocci 6:18</p> <p>BOO-chee 6:15,16</p> <p>Box 1:14</p> <p>branch 4:20 9:11 14:9</p> <p>breakage 12:20</p> <p>briefly 4:5</p> <p>bring 9:17</p> <p>broad 4:6 7:2</p> <p>Bucci 6:15,17,20,20</p> <p>Building 2:8</p> <p>Buprenorphine 4:15,19</p> <p>Bureau 1:3,13 2:4 3:19,21</p> <hr/> <p style="text-align: center;">C</p> <p>C.E 7:11</p> <p>C.F.R 6:1</p> <p>CADC 6:7 13:6,7</p> <p>CADCs 13:5,10</p> <p>call 13:21</p> <p>called 2:7</p> <p>cancel 12:20</p> <p>cancelled 14:8</p> <p>cap 12:12</p> <p>captured 9:16</p> <p>card 3:7,18 6:13</p> <p>cards 5:15</p> <p>care 3:22 4:3 14:11</p> <p>CARF 8:18</p> <p>caseload 8:5,8 12:22</p> <p>caseloads 12:22</p> <p>categories 5:8,10</p>	<p>caveat 9:9</p> <p>Center 9:23 13:2</p> <p>CEO 7:18</p> <p>CER 1:16</p> <p>certified 1:16 5:5,7 6:5,25 7:23 10:12</p> <p>chance 6:8</p> <p>change 4:7,9,10,16 6:24</p> <p>changes 2:24 3:4,6 4:6 5:24</p> <p>choose 13:5,7</p> <p>circulation 2:13</p> <p>city 11:7</p> <p>clarification 8:16</p> <p>Clarifies 5:1</p> <p>Clarify 4:13</p> <p>clients 12:14</p> <p>Clinical 5:23</p> <p>clinically 5:9 8:12 8:14,21</p> <p>clinicians 7:5</p> <p>close 11:3 14:17</p> <p>colleague 10:5</p> <p>come 5:19 13:17,24 14:12</p> <p>coming 4:1 7:5</p> <p>comment 3:7 5:15 7:16 11:10 13:1,3 13:16</p> <p>comments 3:1,24 7:21 9:20 11:1 12:6 13:22 14:13 14:15</p> <p>communities 9:13</p> <p>Community 1:3,13 2:4 3:19,21 14:3</p> <p>compensated 8:2</p> <p>complete 3:7</p> <p>completed 3:17</p> <p>concern 8:23</p> <p>concerns 6:3</p> <p>concluded 14:19</p> <p>conducted 2:10</p> <p>considering 12:20</p> <p>consumers 6:6</p> <p>Contingent 7:19</p> <p>continue 11:13,16 11:23</p> <p>controlled 8:15</p> <p>coordination 7:25</p> <p>copies 2:15</p> <p>Corporation 1:17</p>	<p>correct 10:10</p> <p>correctional 4:14</p> <p>counsel 6:6</p> <p>counseling 5:3,6 8:7</p> <p>counselor 5:7 6:5,25 7:23 12:10,11</p> <p>counselors 10:13 12:13</p> <p>counties 9:11,15</p> <p>County 11:8</p> <p>couple 6:3</p> <p>create 4:20,22 9:7</p> <p>creates 5:8 13:8</p> <p>creating 11:24</p> <p>credential 7:1,2</p> <p>critique 6:23</p> <hr/> <p style="text-align: center;">D</p> <p>data 2:21</p> <p>Dave 5:18</p> <p>David 5:21 6:12 8:4 10:5</p> <p>day 9:14</p> <p>Dayna 14:2</p> <p>December 4:9</p> <p>degree 8:9</p> <p>Deidre 12:7</p> <p>Deirdre 12:9</p> <p>Department 1:2,13 2:5,23 3:8,13,19</p> <p>Department's 3:4</p> <p>Dependence 5:23 10:4</p> <p>deregulate 4:18</p> <p>determine 2:24</p> <p>detoxification 5:9</p> <p>Detroit 9:23 11:7,8</p> <p>Detroit/Wayne 11:8</p> <p>development 13:4,6 13:9,12</p> <p>difficult 10:9,24 12:18</p> <p>directly 3:1,12</p> <p>director 3:20 6:21</p> <p>discharged 11:15</p> <p>disorder 1:5 2:7 4:4 4:10 5:3,6</p> <p>dispensed 8:20</p> <p>distances 9:14</p> <p>distinction 8:3</p> <p>doctor 9:4</p> <p>documents 2:23</p> <p>doses 12:3</p>	<p>double 12:3</p> <p>drive 14:12</p> <p>Drops 9:25</p> <hr/> <p style="text-align: center;">E</p> <p>e-mailed 3:13</p> <p>earlier 6:19 10:6</p> <p>educating 10:20</p> <p>efforts 10:25</p> <p>Electronic 1:16</p> <p>eligible 8:3</p> <p>Eliminates 4:15,17</p> <p>eliminating 11:14</p> <p>emergency 10:22</p> <p>emphasize 7:22</p> <p>employees 7:5</p> <p>employer 13:12</p> <p>Employers 13:4</p> <p>employment 8:1</p> <p>enforce 10:12</p> <p>enforcement 8:24</p> <p>engaged 11:19</p> <p>entails 6:25</p> <p>especially 11:11,12</p> <p>evaluated 14:17</p> <p>everybody 6:22 14:14</p> <p>everybody's 10:7</p> <p>exactly 6:25</p> <p>example 8:17</p> <p>exclusive 4:7</p> <p>executive 6:21</p> <p>explanation 2:16</p> <p>extreme 10:22 14:10</p> <hr/> <p style="text-align: center;">F</p> <p>facilities 4:14</p> <p>family 5:4</p> <p>far 7:4</p> <p>federal 4:14 5:12</p> <p>field 10:8,21,22</p> <p>figures 12:18</p> <p>finally 5:11</p> <p>financially 10:16</p> <p>find 10:10,24</p> <p>Firm 1:17</p> <p>first 4:9 5:18 12:11</p> <p>following 6:1</p> <p>found 2:17 3:15</p> <p>four-year 8:9</p> <p>frame 5:15</p> <p>friends 9:9</p> <p>front 13:6</p>
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<p>frontier 9:11 full-fledged 13:10 further 2:16 9:13</p> <hr/> <p style="text-align: center;">G</p> <p>G 2:8 gaps 12:16 general 2:13 getting 10:22 12:3 give 10:15 gives 13:11 go 8:25 9:13 10:19 going 4:5,6 5:25 6:18 13:4,7 Goldsmith 12:7,8,9 good 2:3 4:1 5:21 9:22 11:6,15,19 11:23 12:8 Gotcha 6:18 grab 3:18 Great 5:14 Gucci 6:17</p> <hr/> <p style="text-align: center;">H</p> <p>hall 2:16 3:16 6:21 hallway 3:18 Harbor 6:21 Health 1:3,13 2:4 3:20,21 14:3 hearing 1:8 2:6,10 2:12,20,24 3:9,15 14:19 Hearings 2:18 help 3:8 5:25 helping 10:20 Hi 12:9 13:2 highlight 8:12 Horvath 3:20 hospitals 4:18 Houghton 14:3,5 hour-and-a-half 14:12 hours 12:13 13:9 14:12 Hoyt 3:22 hundred 9:12</p> <hr/> <p style="text-align: center;">I</p> <p>identify 3:9 Impact 2:15 include 3:5,20 5:9 includes 4:3 inclusive 4:7</p>	<p>increase 10:13 indicate 7:8 indiscernible 13:23 individual 8:21 individuals 8:9 11:11,13 12:5 information 3:15 inside 4:13 institutions 4:14 insurance 14:6 interest 3:6 interested 10:12 interpretation 8:24 interpreted 8:17 invite 3:24 issues 8:1</p> <hr/> <p style="text-align: center;">J</p> <p>Jim 3:21 job 10:18,19 12:17 Jordan 1:13 3:21,25 4:1,2</p> <hr/> <p style="text-align: center;">K</p> <p>Kanzoni 11:3,4,6 Karen 1:16 Kelly 3:22 kind 8:5 12:17 13:8 kinds 9:5 know 7:1,24 8:2 9:15 11:16,18,21 11:22,25 12:3,17 12:23 13:5 14:11 knowing 13:7</p> <hr/> <p style="text-align: center;">L</p> <p>L 1:16 lack 14:6 Lake 14:3,5 language 8:23 9:10 Lansing 1:9,14 2:1 2:9 larger 4:21,23 Larry 3:20 Laughter 10:2 lax 7:6 legislation 4:18 license 4:21,23 8:6,7 11:25 licensed 4:4 5:2 10:22 11:22 Licensing 1:2,13 2:5 3:23 4:3</p>	<p>licensure 4:13,15 limitations 8:6 limited 5:7,7 6:5,24 7:23 8:5,6,7 12:10 12:11,21 limiting 12:23 little 7:2,3,6,6,12 9:9 14:4 load 10:13 local 4:13 located 2:9 9:23 locations 14:4,10 long 11:18 look 6:9 looking 8:16 lot 8:23 12:15,20 LR 1:6 Lucila 9:21,22</p> <hr/> <p style="text-align: center;">M</p> <p>main 6:4 making 11:13 managed 5:9 8:12 8:22 management 5:10 8:13 9:1 manager 4:2 manual 8:18 mark 10:14 marker 7:1 markers 7:9 market 4:21,23 marriage 5:4 Masters 10:22,23 MAT 11:12 Matt 1:13 3:21,24 4:2 Matthew 13:2,14 MBCAP 6:7 7:25 Medicaid 8:18 medically 5:10 9:4 medications 9:2,6 meet 7:2 Mennen 2:8 met 7:8 Methadone 5:12,25 11:12 Michigan 1:1,9,14 2:1,10,13,18 5:22 8:18 9:24 10:3,10 14:6 microphone 5:19 9:25 13:24</p>	<p>Mid-Michigan 14:2 miles 9:12 mobile 4:22 11:21 11:24 14:5 modify 6:8 monitor 8:19 monitored 5:10 9:4 monitoring 8:22 months 6:10 Moore 3:22 morning 2:3 4:1 5:21 9:22 11:6 12:8 moving 12:2</p> <hr/> <p style="text-align: center;">N</p> <p>Naloxone 4:24 Naltrexone 4:16,19 name 2:3 3:10 4:2 5:19,21 6:14,20 9:22 11:6 13:25 necessarily 9:5 necessary 7:9 need 10:10,24 11:14 12:5,13 needed 13:9 Network 1:17 7:19 new 5:8 7:4,5 newspapers 2:13 nice 6:21 non-compliant 11:17 Non-Long-Term 3:22 4:3 notice 2:12 3:15 number 1:17 10:7 11:25</p> <hr/> <p style="text-align: center;">O</p> <p>occur 4:6 offer 8:15 office 2:18 9:12 offices 4:20 officially 13:19 Okay 5:17 7:17 13:16,25 14:13 ones 7:21 9:16 open 7:22 opening 14:10 Opioid 5:23 10:4 opportunities 13:12 opportunity 2:20 6:22</p>	<p>order 2:7 9:14 organization 3:10 Ottawa 2:9 outpatient 4:20 5:25 overdose 12:3 oversight 4:4 overview 4:7</p> <hr/> <p style="text-align: center;">P</p> <p>P.A 2:11 p.m 3:14 P.O 1:14 part 3:3 6:1 7:24 part-time 10:18,19 12:17 particular 7:2,7,21 9:8 particularly 8:11,13 patient 6:11 patients 6:6 10:11 10:15,15,18 12:19 13:8,11 14:7,7,11 14:11 pay 12:19 people 9:15 10:12 11:15,16 12:2,19 12:19,20,25 13:15 percent 14:8 person 5:18 9:21 11:2 Peter 6:13,20 7:15 ph 6:15 physician 8:21 9:2,3 9:7 plan 13:6 plans 13:4,9,12 please 3:1,3,5,9 5:19 podium 3:25 points 4:8 policies 8:18,18 policy 4:24 possibly 10:18 postmarked 3:14 potential 12:3 potentially 6:9 14:5 preferably 7:4 prepare 3:9 7:13 prescribed 8:20 prescriptions 8:20 present 2:21 presented 2:24 prevention 4:17 previous 4:10</p>
--	--	---	--	---

<p>previous-mentioned 4:19 Price 7:18,18 probably 14:8 problematic 9:7 procedure 4:24 Procedures 2:11,20 process 7:10 professional 5:5 7:9 8:7 10:8 professionals 5:2 10:21,24 11:9 program 3:23 8:13 8:21 9:4 programming 7:7 programs 1:5 2:7 4:4,11,16 5:9,12 5:25 8:19 9:1 progressing 6:9 Project 11:7 pronounce 6:14 proposed 2:22,25 3:2,5 4:12 11:11 provide 5:3,6 7:9 10:14 11:23,25 12:4 14:10 provider 7:20 12:2 providers 8:1 12:1 provision 11:21 public 1:8 2:12,20 2:21 3:6,15,24 5:14 7:16 14:13 14:19 published 2:12,14 Pursuant 2:19 put 14:4</p> <hr/> <p style="text-align: center;">Q</p> <p>question 6:5,8 questions 2:21 3:2,3 8:12 quick 13:3 quicker 7:12 quite 9:7,7</p> <hr/> <p style="text-align: center;">R</p> <p>R-325.1381 6:4 R-325.3381 10:6 ratio 5:7 6:6 really 6:1 8:16,23 9:7 10:11 reason 11:17 13:11 reasons 3:5</p>	<p>receive 9:19 received 14:15 receiving 11:12,19 recess 13:17,18 recipient 5:7 9:8 record 3:9 13:19 14:18 Recorded 1:16 Recorder 1:16 Recovery 7:19 11:7 reduction 8:8 reference 9:1 referred 10:6 referring 12:10 regarding 2:6,22 3:2 8:12 13:3 regards 10:6 Register 2:14 Registration 1:17 Regulatory 1:2,14 2:5,15 relate 3:1 related 7:22,23 reliable 7:8 remember 5:19 remote 9:13 REPORTER 13:24 Reporting 1:17 representing 5:22 7:19 11:8 require 4:18 required 4:13 requirements 4:17 5:1 Requires 4:24 residential 5:8 review 3:4 reviewed 14:16 revisions 11:11 ride 14:9 rides 14:6 risky 9:8 role 13:3 rule 1:6 2:17 4:5,9 4:10,16,17 5:24 6:24 11:14 rules 1:4 2:6,18,22 2:25 3:2,2,5 4:9 4:12 rural 14:5 Ryder 9:21,22,22 10:1,3 12:16 13:2 13:2</p>	<hr/> <p style="text-align: center;">S</p> <p>Sam 7:18 9:19 satellite 9:10 14:4 14:10 saying 5:24 scheduled 14:7 schedules 5:12 12:16 scheduling 12:11,14 screening 4:15,19 5:11 section 2:19 4:3 secure 8:3 see 6:21,24 8:5 9:6 12:22 13:6 14:12 seeing 13:16 14:14 seen 9:2,3 12:19 self-administration 8:19,22 sense 10:16 separate 11:25 serve 4:21,23 service 1:5 5:8,10 10:10 11:23 12:1 services 4:20,22 5:3 5:6,23 7:9 8:2 11:19 12:5 14:3 servicing 10:17 SET 1:6 sets 2:17 severe 14:6 Shock 13:23 14:2,2 shortage 10:7 show 12:21 sick 11:17 significant 4:8 8:1 significantly 6:1 single 4:21,22 site 9:5 situation 9:8 six 6:10 smooth 7:10 social 8:6 10:8,23,23 10:23 somebody 8:6 sort 7:11 source 7:8 speak 5:16 6:14 speaking 3:11 specific 3:5 8:8,14 9:10 specifics 6:24 sped 7:6,11</p>	<p>spend 10:20 staff 3:19 10:8,10 staffing 5:1 standards 5:13 Star 9:23 13:2 start 3:24 5:16 started 9:3 state 1:1 3:22 4:3,14 5:19 10:9 13:25 statement 2:15 8:14 statements 3:12,13 status 7:24 Street 2:9 submit 3:3 13:22 submitted 3:12 7:20 substance 1:5 2:7 4:4,10 5:3,6 11:9 substances 8:16 SUD 4:5 7:19 suggested 3:4 support 11:10 sure 3:1 10:7 11:13 12:2,4,4 Systems 1:3,13 2:5 3:20,21</p> <hr/> <p style="text-align: center;">T</p> <p>take 13:16 take-home 5:11 takes 6:7 7:24 talking 8:4 talks 6:4 Tammy 1:12 2:3 ten-minute 13:16 Ten16 7:18 terms 7:23 8:4 9:1 test 7:7,12 testify 3:9,17 testimony 2:23 3:3 thank 4:1 6:11,12 6:22 7:14,15 9:17 9:19 10:25 11:1 12:5,6,23,24 13:13,14 14:14 Therapeutics 12:9 therapists 5:4 they'd 7:13 thing 7:11,11 8:11 11:20 things 8:10 9:6 12:1 think 5:25 7:10 8:25 11:19,23 13:10 thirty 10:13,17</p>	<p>three 2:12 6:7 8:13 time 5:15 7:17 10:20 10:25 13:7 14:8 today 3:14 4:2,5 9:17 14:15,16 ton 13:5 touch 4:5 train 12:18 training 5:1 7:5 10:14 12:13,14,15 treatment 5:12,23 10:4,15 11:12,14 11:16,18 tried 12:10 two 8:25 9:14 14:12</p> <hr/> <p style="text-align: center;">U</p> <p>U.P 9:10 understand 8:10 12:12 understanding 7:24 unit 11:21 units 11:24 14:5 use 1:5 2:7,23 4:4,10 5:3,6</p> <hr/> <p style="text-align: center;">V</p> <p>vague 7:3 valid 7:8,14 verbally 14:16 Victory 5:23 views 2:21</p> <hr/> <p style="text-align: center;">W</p> <p>want 6:13 7:21 8:11 11:15 wanted 6:3 9:17 10:5 11:10 we'll 14:1 we're 8:16 13:19 14:17 we've 7:20 12:10 website 2:17 Wednesday 1:9 2:2 week 9:14 Welcome 12:7 West 2:9 white 3:7 5:15 Williams 2:8 wish 3:7,17 withdrawal 5:10 8:13,25 withhold 9:6</p>
--	---	--	---	---

wonder 12:11	6			
wondering 9:11	6 10:7			
work 8:6 10:8,23,23 10:23 12:4	65 13:8			
working 9:11	7			
written 3:12,13 7:21 9:16,20 14:16	8			
X	8151 1:17			
Y	9			
yeah 13:25,25	9:01 2:2,8			
year 6:10 7:11	9:21 13:18			
years 6:7	9:30 13:17,18,20			
Z	9:32 14:17,19			
0	95 14:8			
0-0-0- 14:20				
1				
1-800-632-2720 1:18				
15 2:14				
1969 2:11				
2				
2018 4:9				
2021-90 1:6				
2022 1:9 2:2,14				
24/7 9:5				
3				
306 2:11				
30664 1:14				
31 1:9 2:2				
31st 2:8 3:14				
32 6:6 12:14				
32-to-one 6:10 13:4				
35 12:14				
3592 1:16				
4				
42 6:1				
45 2:19				
48909 1:14				
5				
5 3:14				
50 6:10				
50-to-one 6:9				
525 2:9				