AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
PROGRAM COMMITTEE MEETING

Thursday, December 12, 2024 at 5:00 pm

Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
Chris Girard, Ch				Pam Schumacher				BABH: Heather Beson, Joelin Hahn, Chris Pinter, and Sara McRae
Sally Mrozinski, V Ch				Robert Pawlak, Ex Off				
Jerome Crete				Richard Byrne, Ex Off				
Toni Reese								Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Rose Home Transition, C. Pinter 4.2) Medicare Physician Fee Schedule Final Rule 2025, C. Pinter 4.3) Strategic Leadership Team (SLT) Re-Organization, C. Pinter 4.4) State Legislative Update, C. Pinter 4.5) Program Committee Changes for 2025, S. McRae		4.1) No action necessary 4.2) No action necessary 4.3) No action necessary 4.4) No action necessary 4.5) No action necessary
5.	Adjournment	M - S - pm	MA

Calendar Year 2025 Physician Fee Schedule Final Rule: Mental Health and Substance Use Policy Highlights[1]

Section-by-Section Final Rule Summary

November 2024

In November 2024, the Centers for Medicare and Medicaid Services (CMS) issued the calendar year (CY) 2025 Physician Fee Schedule (PFS) Final Rule (PFS Final Rule fact sheet; press release; Shared Savings Program fact sheet). This annual rulemaking revises payment policies under the Medicare PFS and makes other policy changes to payments under Medicare Part B. The rule is effective Jan. 1, 2025.

The finalized CY 2025 conversion factor is $32.35, a decrease of $0.94 (2.8%) from the CY 2024 PFS conversion factor. CMS arrived at this figure by applying a 0.05% positive budget neutrality update and, as required by statute, removing 2024's temporary 2.93% payment increase. Given the budget neutrality requirements and finalized policies, the estimated impact on total allowed charges of all the finalized changes varies by specialty. For more information, see Table 110: CY 2025 PFS Estimated Impact on Total Allowed Charges by Specialty in the final rule (Page 2,326).

Policy updates from the final PFS rule include:

- Extension of some telehealth flexibilities permitted under CMS' authority.
- Updated payment for social determinants of health (SDOH) risk assessments as a part of opioid use disorder (OUD) intake activities furnished at opioid treatment programs (OTPs).
- Establishment of a new add-on code to account for coordinated care, referral services and peer supports at OTPs.
- Payment and coding for safety planning intervention and post-discharge follow-up.
- Establishment of payment for digital mental health treatment device services.
- Creation of six G codes for interprofessional consultation through communications technology for mental health specialty providers.
- Summarized responses to CMS' request for information on Certified Community Behavioral Health Clinics (CCBHCs).

The following examines the mental health and substance use policies finalized under the numbered section in the order they appear in the final rule.

[1] Information in this document is for educational and informational purposes only, and nothing herein is intended to be, or shall be construed as, legal or medical advice or as a substitute for legal or medical advice. Any reliance on such information is expressly at your own risk.

Determination of PE RVUs

Practice Expense Methodology

For CY 2025, CMS incorporated the available utilization data for two new specialties, marriage and family therapist (MFT) and mental health counselor (MHC), which it recognized effective Jan. 1, 2024, in accordance with section 4121 of the 2023 Consolidated Appropriations Act. CMS proposed to use proxy practice expense per hour (PE/HR) values for these new specialties — as there is no Physician Practice Information Survey data for them — by cross walking the PE/HR from specialties that furnish similar services in the Medicare claims data from Licensed Clinical Social Workers. CMS is finalizing the proposed PE/HR crosswalks for the MFT and MHC specialties.

Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI)

Given CMS' aim to balance PFS payment stability and predictability by incorporating new data through more routine updates to the Medicare Economic Index (MEI), CMS did not propose to incorporate the 2017-based MEI in PFS rate setting for CY 2025. In response to solicited comments on this approach, CMS summarized the comments received and noted suggestions to investigate a separate MEI for behavioral health to adequately and appropriately value outpatient mental health and substance use services. CMS appreciated commenters' feedback related to updating PFS rate setting and will consider the feedback in future rulemaking.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Beginning Jan. 1, 2025, many Medicare telehealth service statutory requirements that were in place prior to the COVID-19 public health emergency will retake effect for most telehealth services. The final rule extends flexibilities that are within CMS' authority, absent Congressional action.

Changes to the Medicare Telehealth Services List

CMS is finalizing as proposed the addition of caregiver training services to the Medicare telehealth services list for CY 2025 on a provisional basis (CPT codes 97550, 97551, 97552, 96202 and 96203; HCPCS codes G0541-G0543 [GCTD1-3] and G0539-G0540 [GCTB1-2]).

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS is continuing to suspend the frequency of limitations for subsequent inpatient visits, nursing facility visits and critical care consultations. CMS notes that removing such restrictions for CY 2025 will allow an additional year of data to be gathered, to determine how practice patterns are evolving and what, if any, changes to frequency limitations should be made on a permanent basis.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

CMS will permanently change the regulatory definition of an interactive telecommunications system to include two-way, real-time, audio-only communication technology for any telehealth services furnished to beneficiaries in their homes, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system that includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the patient and distant site physician or practitioner, but the patient is not capable of, or does not consent to, the use of video technology. CMS clarified that no additional documentation, except for the appropriate modifier, is needed.

Distant Site Requirements

Through CY 2025, distant site practitioners will be permitted to use their currently enrolled practice location instead of their home address when providing Medicare telehealth services from their home.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS is finalizing as proposed, that it will continue to define direct supervision in a way that permits the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through Dec. 31, 2025.

Additionally, CMS is electing to permanently extend this definition for a certain subset of services that are furnished incident to a physician's service, when they are provided in their entirety by auxiliary personnel working under the direct supervision of the physician (or other practitioner), excluding audio-only communications. This subset of services includes those for which the underlying HCPCS code has been assigned a Professional Component (PC)/ Technical Component (TC) indicator of 5, as well as services described by CPT code 99211 ("Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional").

For all other services furnished "incident to" that require direct supervision, CMS will continue to permit direct supervision be provided through real-time audio and visual interactive telecommunications technology only through Dec. 31, 2025. CMS noted that commenters provided additional services to consider for permanent adoption, as they are inherently low risk for purposes of permitting direct supervision through virtual presence, such as behavioral health and therapy services. CMS will consider adding services for which direct supervision can include virtual presence in future rulemaking.

Telehealth Place of Service Code

CMS clarified that claims for telehealth services billed with place of service 10 ("telehealth provided in patient's home") will continue to be paid at the non-facility PFS rate for CY 2025 and beyond.

Valuation of Specific Codes

Annual Alcohol Screening (HCPCS codes G0442 and G0443)

CMS is finalizing the work RVU increase for HCPCS codes G0442 and G0443 as proposed. CMS clarified that practitioners who practice in settings such as CCBHCs and community mental health centers (CMHCs), who are enrolled in Medicare and who are able to bill directly for their services may be able to bill for these codes under the PFS. For the direct PE inputs, CMS agreed with commenters that it would not be typical for the clinical staff to administer the questionnaire, clarify questions as needed and record the answers in the patient's electronic medical record in the five minutes recommended by the RVS Update Committee (RUC) and is finalizing as proposed to maintain the current 15 minutes of clinical labor time for the CA021 activity for HCPCS code G0442. CMS is finalizing the RUC-recommended direct PE inputs for HCPCS code G0443 without refinement.

Annual Depression Screening (HCPCS code G0444)

CMS is finalizing the RUC-recommended work RVU for HCPCS code G0444 as proposed and will maintain the current 15 minutes of clinical labor time and corresponding equipment time. Similar to the above, CMS clarified eligible providers' ability to bill for this code in CCBHC and CMHC settings.

Payment for Caregiver Training Services

CMS is finalizing the proposal to establish new payment and coding for caregiver training for direct care and support. CMS notes that the finalized codes focus on specific clinical skills aimed at the caregiver providing hands-on treatment, reducing complications and monitoring the patient. Importantly, the agency highlights that the caregiver training services (CTS) must be consistent with the beneficiary's treatment plan and designed to result in the intended patient outcome. For CY 2025, CMS is finalizing actions to add three new HCPCS codes — GCTD1, GCTD2 and GCTD3 — to be crosswalked with existing CPT codes 97550, 97551 and 97552 respectively. In addition to establishing new payment and coding for caregiver training for direct care and supports, the CY 2025 PFS rule also finalizes the establishment of a new coding and payment for caregiver behavior management and modification training that is provided to the caregiver of an individual patient. As described in a section above, CMS is additionally finalizing the proposal to allow services to be accessed through telehealth. Finally, in the CY 2024 PFS rule, CMS finalized a requirement that the provider must obtain the beneficiary's consent for the caregiver to receive the caregiver training services. In the CY 2025 PFS rule, the agency is finalizing that the beneficiary may provide such consent verbally.

CMS also clarified that payment for CTS may be made to physicians, nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants and clinical psychologists under the PFS when they bill for CTS personally performed by them or by other practitioners or auxiliary personnel as an incident to their professional services. Clinical social workers, MFTs and MHCs can bill Medicare directly for CTS they personally perform for the diagnosis or treatment of mental illness, but they cannot directly bill Medicare for CTS provided by auxiliary personnel.

Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136))

CMS acknowledged comments received regarding their request for information (RFI) on the newly implemented HCPCS codes for community health integration (G0019, G0022), principal illness navigation (G0023, G0024), principal illness navigation — peer support (G0140, G0146) and SDOH risk assessment (G0136) and may consider these comments in future rulemaking.

Enhanced Care Management (section II.G.)

To improve primary care, CMS is finalizing its proposal to establish payment beginning Jan. 1, 2025 for a new set of advanced primary care management (APCM) services through three new HCPCS codes — G0556, G0557 and G0558 — that encompass a broader range of services and simplify billing for clinicians providing APCM. Collectively, as detailed in the code descriptors, the three new codes would provide payment for a broad range of APCM services that are: (1) provided by clinical staff and directed by a physician or other qualified health professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services; (2) for a patient with multiple chronic conditions expected to last at least 12 months, provided by clinical staff and directed by a physician or other qualified health professional who is responsible for all primary care; and (3) for a patient who is a Qualified Medicare Beneficiary with multiple chronic conditions, provided by clinical staff and directed by a physician or other qualified health professional who is responsible for all primary care. CMS is also finalizing the proposal to allow concurrent billing for behavioral health integration, community health integration, principal illness navigation, principal illness navigation — peer support, the SDOH risk assessment, remote physiological monitoring and remote therapeutic monitoring services in the same month as APCM services.

Additionally, in the proposed rule, CMS issued an RFI on additional payment policies that should be considered for advanced primary care services and indicates that it intends to use the comments received to inform future rulemaking. In response to comments urging consideration of the importance of including behavioral health in future rulemaking as it relates to advanced primary care, CMS agreed with commenters that behavioral health is important in the context of overall health and will consider comments recommending strategies for further integration for future rulemaking.

Advancing Access to Behavioral Health Services

Safety Planning Interventions and Post-Discharge Telephonic Follow-up Contacts

CMS established separate coding and payment under the PFS for safety planning interventions by creating a standalone code, G0560, that can be billed in 20-minute increments — revised from an initially proposed add-on code — for use when these interventions are performed by the billing practitioner. The billing practitioner could be any practitioner who is authorized to furnish services for the diagnosis and treatment of mental illness, and CMS is finalizing as proposed that services under this code would need to be personally performed by the billing practitioner for CY 2025, but it will continue to consider this issue for future rulemaking. CMS is also finalizing the addition of the HCPCS code G0560 to the Medicare telehealth services list.

Additionally, CMS is creating a monthly billing code, G0544, to describe specific protocols involved in furnishing post-discharge follow-up contacts following a beneficiary's discharge after a crisis encounter. CMS is not finalizing a set duration that this could be billed for; rather, CMS will allow this code to be billed and paid for as long as the service is medically reasonable and necessary. CMS is also finalizing as proposed that the billing practitioner will need to meet a threshold of at least one real-time telephone interaction with the patient in order to use this code. CMS clarifies that HCPCS code G0544 can be billed by practitioners in any instance in which the beneficiary has been discharged following a crisis encounter, including discharge from psychiatric inpatient care or crisis stabilization. CMS also clarifies that the services described by HCPCS code G0544 can be provided by auxiliary personnel incident to the services of the billing practitioner, in accordance with the requirements of § 410.26. Finally, CMS will allow consent to be obtained either prior to or during the initial phone call.

Digital Mental Health Treatment (DMHT)

In the final rule, CMS established payments to billing practitioners for digital mental health treatment (DMHT) devices furnished to professional behavioral health services providers, used in conjunction with ongoing behavioral health treatment and in accordance with their Food and Drug Administration (FDA)-classified use, by creating three new HCPCS codes. CMS will monitor how DMHT devices are used as part of overall behavioral health care.

A physician or other practitioner who is authorized to diagnose, evaluate and treat a mental health disorder may prescribe or order a DMHT device as permitted under the device's FDA clearance, in accordance with state prescriptive authority, and may report HCPCS code G0552 ("Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan"). Auxiliary personnel meeting the requirements of 42 CFR §

410.26(a)(1) may only provide part of the initial education and onboarding described in the code. Of note, HCPCS code G0552 is not payable in cases where the billing practitioner does not incur a cost in acquiring and furnishing the DMHT device, or where a patient procures the DMHT device independent of the practitioner; in this benefit category, payment for the DMHT device as a supply incident to a practitioner's professional services must be a supply cost that the practitioner has incurred. CMS is also finalizing two HCPCS codes with refinement:

- G0553 — "First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the DMHT device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month."
- G0554 — "Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the DMHT device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month. (List separately in addition to HCPCS code G0553.)"

Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions

CMS created six new G-codes that will provide payment for interprofessional consultations performed through communications technology by practitioners in specialties whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including clinical psychologists, clinical social workers, MFTs and MHCs. CMS is also finalizing the consent requirements for HCPCS codes G0546-G0551 as proposed.

Comment Solicitation on Payment for Services Furnished in Additional Settings, including Freestanding SUD Treatment Facilities, Crisis Stabilization Units, Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs)

CMS summarized comments received from the RFI on coding and payment for intensive outpatient program (IOP) services, crisis stabilization services, freestanding substance use disorder (SUD) treatment facilities and CCBHCs, noting they will take these comments into consideration for future rulemaking.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

In-Person Visit Requirements for Remote Mental Health Services Furnished by RHC and FQHCs

CMS is finalizing the proposal to continue to delay the in-person visit requirement for mental health services furnished to beneficiaries in their homes via communication technology by RHCs and FQHCs until Jan. 1, 2026. CMS noted that they may consider an additional extension in future rulemaking.

Intensive Outpatient Program Services (IOP)

CMS is finalizing a payment rate for four or more services per day in an RHC or FQHC setting, to ensure parity for IOP services across various settings while still monitoring access. This payment rate will be aligned with the associated rate for hospital outpatient departments and updated annually. CMS noted it believes that establishing a payment for four or more services per day will provide parity for IOP services across the various settings, with site neutral payments.

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Conditions for Certification and Conditions for Coverage (CfCs)

CMS is finalizing the proposal to require explicitly that RHCs must provide primary care services rather than being "primarily engaged" in furnishing these services. CMS noted it believes this policy provides RHCs with greater flexibility in the services that they provide by no longer placing parameters on the amount of primary care services provided. Additionally, CMS withdrew the proposal with respect to FQHCs, to avoid the potential for unintended limitation of access to care. CMS also withdrew the proposal to codify the statutory requirement that RHCs cannot be a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Telecommunication Flexibilities for Periodic Assessments and Initiation of Treatment with Methadone

CMS is finalizing the proposal to permanently allow OTPs to furnish periodic assessments via audio-only telecommunications beginning Jan. 1, 2025, as long as all applicable requirements are met and the use of these technologies is permitted under the applicable Substance Abuse and Mental Health Services Administration (SAMHSA) and Drug Enforcement Administration (DEA) requirements at the time the services are furnished.

CMS is also finalizing the proposal to allow the OTP intake add-on HCPCS code, G2076, to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone, to the extent that the use of such technology to initiate treatment with methadone is authorized by the DEA and SAMHSA at the time the service is furnished and if the OTP determines that an adequate evaluation of the patient can be accomplished via such technology.

Reforms to 42 CFR Part 8

Following recent SAMHSA regulatory reforms for OUD treatment, finalized at 42 CFR part 8, CMS is updating payment for SDOH risk assessments as part of OUD intake activities. The agency specifies that this payment is for assessments determined by OTPs to be medically reasonable and necessary for OUD treatment or diagnosis. Based on feedback regarding the need for multiple SDOH risk assessments to address unmet needs impacting OUD treatment outcomes, CMS is finalizing an update to the payment code for SDOH risk assessments during periodic assessments, G2077, to include the value of the non-facility rate for SDOH risk assessments (G0136), consistent with the finalized update to the code for intake activities, G2076. Additionally, CMS is finalizing the proposed descriptor for G2076 with revisions to reflect this change and to include all appropriately licensed professionals conducting OTP assessments.

In response to comments on the RFI for coordinated care at OTPs, CMS is establishing three new add-on codes for coordinated care/referral services (G0534), patient navigational services (G0535) and peer recovery support (G0536). Moreover, CMS encourages OTPs to engage in discussions with patients regarding coordinated care and/or referral services, patient navigational services and/or peer recovery support services prior to furnishing and billing for these services under the Medicare OTP benefit. CMS expects OTPs to document how coordinated care and/or referral services, patient navigational services and/or peer recovery support services relate to the treatment and diagnosis of OUD in the patient's medical record. CMS is not limiting the types of providers that can furnish these services under the Medicare OTP benefit and is not finalizing limitations to how frequently these services may be furnished.

Payment for New FDA-approved Opioid Agonist and Antagonist Medications

For CY 2025, CMS is establishing payment for new opioid agonist and antagonist medications approved by the FDA. Specifically, CMS is finalizing a new add-on code, G0532, and payment for nalmefene hydrochloride nasal spray, which is indicated for the emergency treatment of known or suspected opioid overdoses. CMS is finalizing monthly payments for a new injectable buprenorphine product, Brixadi, through the existing code for monthly injectable buprenorphine, G2069. While the agency originally proposed using this code for weekly payments as well, the final rule establishes a new weekly payment code, G0533. In response to stakeholder feedback, CMS will use a volume-weighted average sale price (ASP) methodology to calculate the drug component of the monthly payment, which CMS anticipates will provide a more accurate reflection of market utilization and costs.

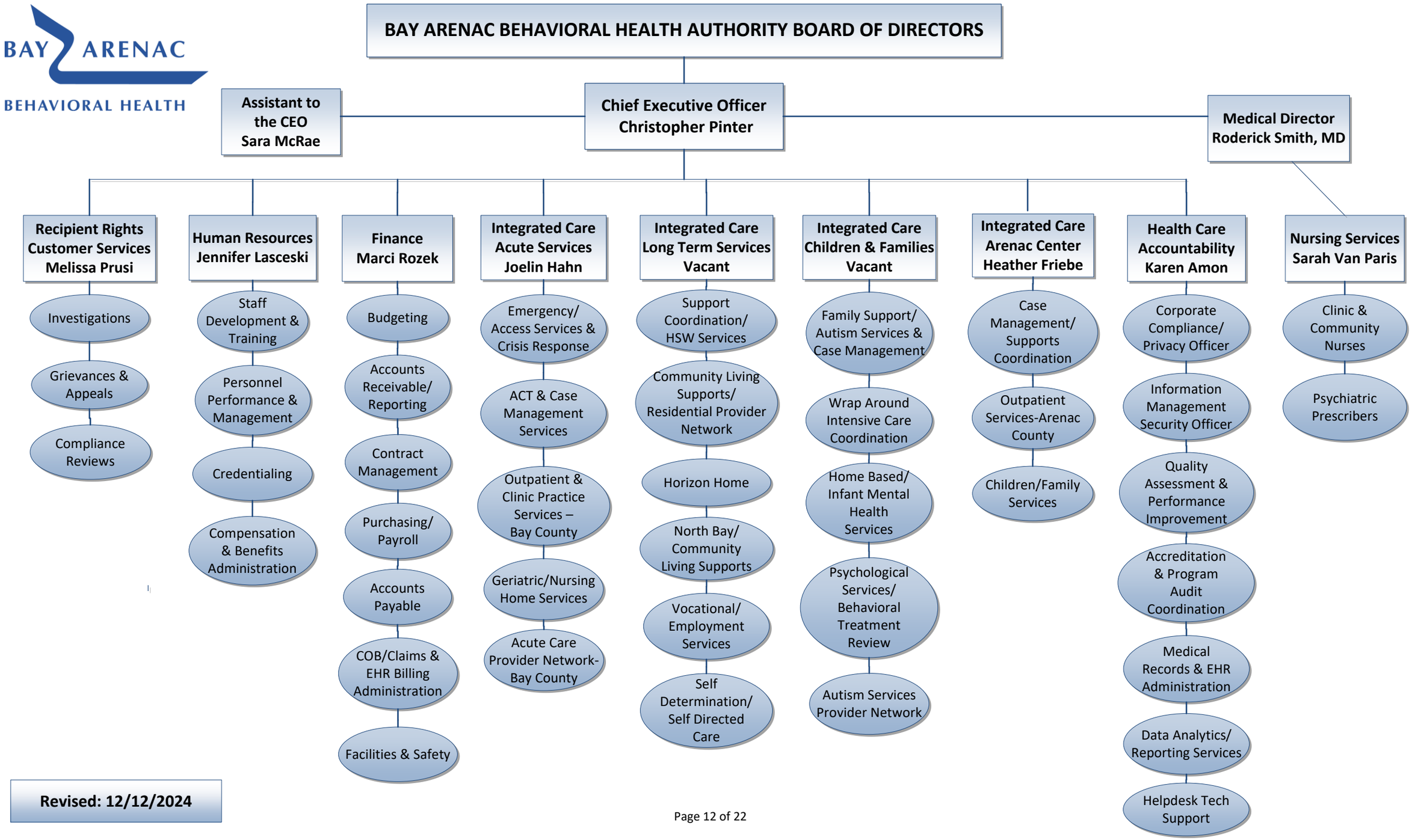
Clarification to require an opioid use disorder diagnosis on claims for OUD treatment services

In the final rule, CMS clarifies that all claims submitted to Medicare under the OTP benefit must include an OUD diagnosis, and it indicated an intention to issue additional guidance on attaching diagnostic codes to claims.

Medicare Part B Payment for Preventive Services (§§ 410.10, 410.57, 410.64, 410.152)

Proposed Fee Schedule for Drugs Covered as Additional Preventive Services (DCAPS)

CMS is finalizing its proposal to cover certain drugs or biologicals under the "additional preventative services" benefit category pursuant to the Social Security Act. Notably, coverage for PrEP for HIV infection prevention may be included under this benefit category. Regarding payment for drugs covered under the additional preventative services benefit, CMS is establishing a fee schedule that uses the existing Part B ASP methodology under section 1847A of the Social Security Act, when ASP data is available. The agency is also applying payment limits for administering and supplying drugs covered as additional preventive services, similar to those currently set forth under the ASP methodology for Part B drugs, if ASP data is available. Finally, the rulemaking applies payment limits for the supply and administration of drugs covered as additional preventive services. Specifically, CMS is establishing a payment limit of $24 to a pharmacy for the first prescription that the pharmacy supplies to a beneficiary in a 30-day period, and a payment limit of $16 to a pharmacy for all subsequent prescriptions. For drugs under this benefit category administered by a physician or a non-physician practitioner, the payment limit for administration will be aligned with the administration fee for other drugs under Part B provided as incident to physician services. Notably, no cost sharing will apply for the administration or supplying of drugs covered as additional preventive services.



Revised: 12/12/2024


Integrated Services Director Primary Care
Joelin Hahn
2400 Cases
Integrated Services Director Long Term Care
Vacant
400 Cases
Integrated Services Director Children & Families
Vacant
400 Cases
Integrated Services Director Arenac Center
Heather Friebe
600 Cases
Emergency & Access Services
Stacy Krasinski
Access Supervisor
Ann Sous
MRT Supervisor
James Spegel
Case Management & ACT
Alison Gruehn
ACT Supervisor
Karen Heinrich
CSM Team Leader
Taylor Keyes
Outpatient and Psychiatric Clinic
Amy Folsom
Supports Coordination
Melanie Corrion
SC Team Leader
Stephani Rooks
HSW Team Leader
Jackie Kish
Community Living Supports & Vocational
Nicole Sweet
Horizon Home Supervisor
Justine Blair
North Bay Supervisor
Lynn Blohm
Children and Family Services
Emily Gerhardt
Home Based/ Infant Mental Health Supervisor
Kelli Maciag
Autism Supervisor
Amanda Johnson
Psychological Services/BTRC
Heather Nix
Arenac Center Supervisor
Pam Van Wormer
Medical Director
Roderick Smith
Nursing Manager
Sarah Van Paris
Clinic Nurse Coordinator
Deidra Mosceski
Prescribing Staff
MEDICAL STAFF

Community Mental Health Association of Michigan

2024 Lame Duck Tracker – Week 1 Update

SBs 915 – 918 - Assisted Outpatient Treatment Bills

SBs 915-918 passed the FULL Senate on Wednesday, December 4 – bills were referred to the House Health Policy Committee.

- Allows law enforcement officers to take someone in for a psychiatric examination if they have "reasonable cause" to believe they need community mental health treatment. Currently, officers must personally witness signs of uncontrolled mental illness.
- Expands petition for access to assisted outpatient treatment to additional health providers
- Provides outpatient treatment for misdemeanor offenders with mental health issues
- Allows use of mediation as a first step in dispute resolution

SBs 651-654 – Tobacco Use, Sales and Prevention

SBs 651-654 passed the FULL Senate on Thursday, December 5 – bills have not been referred to a House Committee yet

- Would end the sale of flavored tobacco products (including flavored e-cigarettes and menthol-flavored cigarettes)
- Require tobacco retailers to be licensed
    - Establishes licensure requirements for retailers ($1500 application fee goes into a Nicotine and Tobacco Regulation Fund, LARA would put towards enforcement and compliance)
    - MI is one of only 10 states that do not require a license to sell tobacco
- Tax e-cigarettes and vaping products containing nicotine for the first time
- Increase tobacco taxes
- Eliminate local preemption on tobacco restrictions
- Repeal penalties that punish kids for tobacco purchase and use.

SB 802 – Mental Health and SUD Registry (CMHA Opposes)

SB 802 passed out of the Senate Health Policy Committee on Wednesday, December 4 – bill is on the Senate Floor

- Require the Department of Health and Human Service's (DHHS's) electronic inpatient psychiatric bed registry to include community-based services.
- Require community mental health services programs to provide the DHHS with the number, type, and other pertinent information on the community-based mental health and substance use disorder services available in the local area.
- Add acute care hospitals or emergency department staff and community mental health services programs to the list of required representatives on the committee that guides the operations of the registry.
- Require the DHHS to compile a list of available community mental health services programs and substance use disorder services program and disclose that information to individuals that used the Michigan Crisis and Access Line.

CMHA believes SB 802 adds another unnecessary administrative burden onto the system. This information is already provided to MDHHS and is available on local websites. This bill is being pushed by the Michigan Hospital Association in the name of transparency.

HB 4693 – Open Meetings Act Change

The House Local Government Committee heard testimony only on HB 4693 on Wednesday, December 4. Chair John Fitzgerald said the committee would be voting the bill out next week.

House Bill 4693 would amend the provisions to allow a public body to meet electronically under any circumstances if the following conditions are met:

- No member of the public body is directly elected by the voters to serve on the body.
- No member is compensated for their service.
- The body is not legally authorized to directly raise revenue by imposing any tax, millage, assessment, or fee on persons, property, or transactions within its jurisdiction.
    - A public body's receipt of one-time funding from another governmental entity, including the state or federal government, would not disqualify it from being able to meet remotely under these provisions.

The public body would have to establish procedures that do all of the following:

- Allow absent members to participate in, and vote on, business before the public body and include procedures for two-way communication.
- Provide a way to notify the public of a member's absence and let them know how to contact that member before the meeting to give input on anything that will come before the public body.
- Require a member attending remotely to specify the county, city, township, or village and state where they are physically located.

HB 5785 – Limited Licensed Psychologist Supervision

HB 5785 passed out of the House Health Policy Committee on Thursday, December 5 – bill is on the House Floor

- Change criteria regarding limited licensese to practice psychology (notably by removing supervision requirements for a person practicing under a limited license and requiring a longer period of supervised postgraduate experience to apply).
- Allow the two-year temporary limited license for individuals getting their required amount of supervised postgraduate experience to be extended for two additional two year periods (instead of just one), for a total of six years (instead of four).

HBs 5371 & 5372 – CCBHC Codification

HBs 5371 & 5372 passed out of the House Health Policy Committee on Thursday, December 5 – bill is on the House Floor

The bills would codify the CCBHC program into state statute, for example it would:

- Would require DHHS to develop, in accordance with federal law and regulations, a prospective payment system under the medical assistance program for funding all of the following:
    - A CCBHC.
    - A community mental health service program (CMHSP), nonprofit organization, or private organization that provides mental health services that is certified by DHHS as a CCBHC, is licensed by DHHS, and adheres to all federal CCBHC requirements.
    - A mental health provider who is certified by DHHS as a CCBHC and who adheres to all federal CCBHC requirements.
- Ensure continuing compliance with DHHS licensing and certification requirements.
- Prohibit the state government from implementing a policy that contradicts or interferes with the implementation of federal definitions or requirements for a CCBHC.
- Require the state government to develop a process of determination for additional CCBHC sites in specific geographic regions that must comply with federal CCBHC requirements, to address service area overlap.
- Require the state government to continue to participate with the federal government to implement CCBHCs. The bill states, "To opt out of participation, there must be a vote of the legislature."

HB 5178 – Syringe Service Programs (SSP)

HB 5178 passed out of the House Health Policy Committee on Thursday, December 5 – bill is on the House Floor

This bill allows communities to opt-in to a SSP. Under the bill, the possession, distribution, or delivery of any of the following by an individual who is served by, or who acts as an employee or volunteer for, a program described above would not be a violation of section 7401 or 7403 of the Public Health Code1

or a local ordinance that substantially corresponds to those sections or that provides criminal penalties for the possession of drug paraphernalia:

- A needle or hypodermic syringe, including one that is empty or unused.
- Drug paraphernalia.
- A controlled substance in a trace or residual amount in a used needle, hypodermic syringe, or drug paraphernalia. • Drug testing equipment, including a test strip or reagent.

HB 4833 – Dual Licensure Requirements / SUD

HB 4833 passed out of the House Health Policy Committee on Thursday, December 5 – bill is on the House Floor

Under the bill, except as described below, a person could not establish, conduct, or maintain a substance use disorder services program that offers any service that is a substance use disorder treatment and rehabilitation service unless it is licensed under Part 62.

A license under Part 62 would not be required to provide substance use disorder prevention services.

A license under Part 62 would not be required by any of the following:

- A person that is otherwise licensed to provide psychological, medical, or social services.
- A hospital licensed under Article 17 of the Public Health Code.
- A psychiatric hospital or psychiatric unit licensed under section 134 of the Mental Health Code.

The bill would change references in Part 62 to licensure of a substance use disorder services program so that they would apply only to the licensure of substance use disorder treatment and rehabilitation services.

Finally, the bill would remove a provision that now requires the Department of Licensing and Regulatory Affairs (LARA), before issuing a license to an applicant under Part 62, to provide an opportunity for individuals in the applicant's service delivery area to comment.

HB 6058 – Public Employer Health Insurance Contribution Caps

HB 6058 passed out of the House Labor Committee on Thursday, December 5 – bill is on the House Floor

The bill would increase the hard caps for employer insurance contributions:

- $8,258 for single-person coverage
- $17,271 for individual-and-spouse coverage
- $22,523 for family coverage

These increases represent a jump of 7.25 percent from 2024 levels. The bill maintains an inflationary adjustment tied to the medical care component of the U.S. Consumer Price Index (CPI), but adds a floor of a 3 percent annual increase, ensuring the caps rise even during periods of low inflation. On top of the

indexed or 3 percent increase, the bill also allows for an additional 5 percent increase that would be a subject of bargaining.

However, HB 6058 also makes significant changes to the 80/20 cost-sharing option. PA 152 now requires employers to pay "no more" than 80 percent of the cost of health premiums. HB 6058 would require employers to pay "no less" than 80 percent, effectively opening this provision to collective bargaining.

Lastly, HB 6058 also allows for different bargaining units to have different caps, effectively slating some bargaining units to pay less for health premiums than others.

MAC is concerned this change would reduce predictability for public employers and potentially increase costs. While MAC supports raising the hard caps to better reflect the rising costs of health care, MAC seeks a simpler approach to the readjustment by tying the caps to a more appropriate inflationary index that better tracks health insurance premium increases.

Other Bills that saw NO ACTION this week:

- HB 4707 – Mental Health and SUD Parity expansion (remains on the House Floor)
- HBs 5184 & 5185 – Social Worker Licensure Change (remains in House Health Policy Committee)
- HB 5179 – Fentanyl Testing Strips (remains in Senate Health Policy Committee)
- SB 870 – Open Meetings Act Change for persons with disabilities (remains in House Govt Ops Committee)
- HBs 5077 & 5078 – Naloxone Distribution (remains on Senate Floor)
- SB 542 – Opioid Antagonist Expansion (remains in House Health Policy Committee)
- No supplemental budget action

Program Committee
Monthly Meeting
SLT Facilitator: Joelin Hahn/Heather Beson

	January	February	March	April	May	June	July	August	Sepetember	October	November	December
Items:												
Clinical Program Reviews		x	x		x	x		x	x		x	x
Policies	x	x	x	x	x	x	x	x	x	x	x	x
Clinical Privileges	x	x	x	x	x	x	x	x	x	x	x	x
PNOQMT Notes	x	x	x	x	x	x	x	x	x	x	x	x
Quality Assessment & Performance Improvement Plan										x		
Quality Improvement Quarterly Reports			x			x			x			x
Quality Survey Results/Outcomes (Employee/Provider/Consumer)	x		x									
MDHHS Waiver Review												x
Infection Control Plan									x			
Medical Staff Plan					x							
Strategic Initiatives/Dashboard Review	x			x			x			x		

Other coordination with Board Office:

January 2025

BABH Board of Directors

January 2025

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Dec 29	30	31	Jan 1, 25 New Year's Day/BABH Offices Closed	2 5:00pm Personnel & Compensation Committee	3	4
5	6 5:00pm Recipient Rights Advisory & Appeals Committee	7	8 5:00pm Finance Committee	9 5:00pm Program Committee	10	11
12	13 5:00pm Audit Committee	14	15	16 5:00pm REGULAR BOARD MEETING	17	18
19	20 Martin Luther King, Jr. Day/BABH Offices Closed	21	22	23	24	25
26	27	28	29	30	31	Feb 1

February 2025

BABH Board of Directors

February 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Jan 26	27	28	29	30	31	Feb 1
2	3	4	5	6 5:00pm Corporate Compliance Committee	7	8
9	10 5:00pm Recipient Rights Advisory & Appeals Committee	11	12 5:00pm Finance Committee	13 5:00pm Program Committee	14	15
16	17 President's Day/BABH Offices Closed	18 5:00pm Audit Committee	19	20 5:00pm REGULAR BOARD MEETING (Arenac Center, 1000 W. Cedar Street, Standish, MI 48658)	21	22
23	24	25	26	27	28	Mar 1

March 2025 BABH Board of Directors

March 2025

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 2025

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Feb 23	24	25	26	27	28	Mar 1
2	3	4	5	6 5:00pm Facilities & Safety Committee	7	8
9	10 5:00pm Recipient Rights Advisory & Appeals Committee	11	12 5:00pm Finance Committee	13 5:00pm Program Committee	14	15
16	17 Saint Patrick's Day 5:00pm Audit Committee	18	19	20 5:00pm REGULAR BOARD MEETING	21	22
23	24	25	26	27	28	29
30	31	Apr 1	2	3	4	5