Chairman Nelson and members of the House Appropriations Human Services Division:

My name is Kurt Snyder, and I am the Executive Director of the Heartview Foundation. Heartview is currently offering Medication Assisted Treatment (MAT) to 291 individuals including some at North Dakota State Penitentiary in Bismarck and Dakota Women's Correctional in New England. At any given time, we have over 400 individuals in our care. We employ a psychiatrist, medical providers, psychologists, nurses, addiction counselors, mental health counselors, social workers, peer support specialists, case managers, and residential technicians. Last year we served individuals from 38 of the 53 counties of ND. Of our patient population, over 65% are Medicaid or Medicaid Expansion. (20% Medicaid and 47% ME).

I am here today to voice our support for the re-authorization of Medicaid Expansion. More specifically we support:

Removing the Sunset Clause

- I have a number for you, 47. 47% of our patient population is Medicaid Expansion. Almost ½ of our patient population is covered for only 2 years at a time. How can treatment providers plan expansion efforts into rural or underserved communities with such a vulnerable funding base? How can we be expected to meet the needs and demands of the opioid epidemic without confidence in our funding streams? Please remove the sunset clause!

Retain Medicaid Expansion with a Private Insurance Carrier

We strongly oppose moving Medicaid Expansion under Medicaid for these main reasons:

- First, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was meant to prevent health insurance plans from imposing less favorable benefit limitations on mental health or substance use disorder benefits than on medical surgical benefits. Medicaid Expansion fully complies with MHPAEA. ND Medicaid does not. MHPAEA specifically restricts annual limits. ND Medicaid has annual restrictions on Intensive Outpatient, Partial Hospitalization and High Intensity Residential. Parity also insures that "Medical Necessity" be the standard for authorizing services. Again, ND Medicaid does not follow parity in this respect. ND Medicaid does not utilize accepted clinical standards for authorizations but instead providers must request additional days of coverage that sometimes takes months for approval. If Expansion is moved under ND Medicaid over 67% of our patients would not have the important protections of this federal parity law. The law that prevents discrimination and stigma.

- I have another number for you, 67. 67% of our patient population would be ND Medicaid if Expansion is moved under the Medicaid umbrella. 67% of our patient population would be subject to ND Medicaid's claims processing. This terrifies me! ND Medicaid has testified on many

occasions that clean claims are paid in a timely manner, which we agree upon. The problem, however, is that ND Medicaid denies 33% of Heartview claims, while other commercial payers average under 9%. Furthermore, reprocessing denied claims is extremely difficult with ND Medicaid. We often experience wait times of weeks, and sometimes months to even get a response from Medicaid on a single claim. In January 2019 ND Medicaid gave us a $450,000 cash advance because we were having cash flow issues due to overwhelming outstanding Medicaid claims. As of today, 55% of outstanding claims with ND Medicaid are over 6 months old. In comparison, only 4% of Medicaid Expansion outstanding claims are over 6 months old.

We Support Implementation and Continuation of Commercial Rates

- Finally, I need to address reimbursement rates. Last session there was an amendment that was intended to provide consistent reimbursement rates across providers. However, it turned out that reimbursement rates within substance use providers were not established equitably. A level of care called Partial Hospitalization Program or PHP, (which makes up over 50% of our revenue) was given a higher reimbursement rate to hospital-based programs. Community based programs were given a lower rate which is inherently unfair. I would argue that our quality of care exceeds hospital-based programs because we offer all 3 FDA approved medications for opioid use disorder. Even within the ND Medicaid reimbursement rate structure there is no difference between hospital-based programs and community-based PHP programs.

- According to the American Hospital Association, 18.5% of the payer mix in hospitals is attributed to Medicaid. Most Medicaid Expansion enrollees are childless adults working one or more jobs and in much-needed access to chronic disease management, mental health services and addiction treatment programs. As a result of the needs of this population they are overrepresented in our services. Substance use providers need commercial rates to offset the disproportionate number of patients (67%) within our service structure.

This concludes my testimony, and I would stand for any questions.

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