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Chairman: Committee members

Here in support of SUD Voucher portion of Bill 1012
Representing:

Summit Counseling Services: Outpatient Behavioral Health Agency, located in Williston, Dickinson and Bismarck since 2015

Summit Prairie Recovery Center – Residential Treatment Center, Raleigh ND, south of Flasher

I have worked in Behavioral Health for 20 years plus, in the State system for more than 15 years. Prison System 3 Human Service Centers (Jamestown, Devils Lake, Williston)

1 in 8 people with Substance Use Disorder, new state released by SAMSHA
1 out of 5 people utilize Medicaid/Sanford Expansion type of insurance services.

(Forgiveness, passionate about what I do, non- politically correct, going to say some things that disagree with what has been presented to the legislature)

Grieved and Angered.
Testimony conflicts with (Masters Research paper prepared by me in 2012) utilized by the state in their presentations to justify their positions.

1 Initially to justify their spending thousands on their IDDT Program (Dual Diagnosis with University of Ohio) (2010)

2. Manipulated stats to justify their change to Open Access to justify not spending money on Addiction and individual services. (2014-2015)

3. Utilized to justify the 1915 (I) program. (2020)

4. Now manipulated to indicate too much money is being spent on (Long term) term care (This session)
*Stats are specific to those with developmental disabilities/severe substance use that will not get better due to inability to not get better. Included case management, those that can't drive or totally care for themselves, such as nursing home care, those in subsidized housing, vocational rehab individuals that

need support, not those in short term placement such as treatment that were high functioning and are able to return to high functioning.

*Manipulated statistics –

Rosalie (Director of State Hospital) Presented that the recommendations for "residential" treatment are out of fear and are "overstated" because people are afraid.

Absolutely: People are afraid, who would not be fearful of seeing your family member overdose
Group: Month ago, 12 clients, 9 overdosed in 30 days prior to treatment, 1 of them three times

Narcan, Ambulances Services, First Responders, Air Ambulances
*All of them had attempted outpatient services and could not stop their use.
*All the opioid users – had abused the MAT program medications, purchased them on the street and abused them along with fentanyl.

*It's not FEAR – it's NEED.

Treatment recommendations are not made by the families or the patient, they are made by Bachelor's and Master's Level, Licensed Addiction Counselors using the criteria established and recommended nationally by the American Society of Addiction Medicine. These criteria are based on 6 Dimensions. The score of these dimensions determine placement.

It is being said that MAT treatment is "cost effective".
True it is less costly and can be very effective is done in an evidence-based manner.

However, it is a tool and is being abused. It is to be prescribed and the clients are to participate in treatment programming. One cannot just substitute and not deal with the psychological aspects of addiction. (Again, ever person abusing opioids in treatment at SPRC have abused these medications)
*Many do not want the MAT medications – they want to be totally clean.
*Many cannot afford the MAT medications even if they wanted them.
*Many do not have transportation to continue MAT medications.
*Have already abused the MAT medications.
*Feel forced to take the MAT medications because there are not other services to assist with withdrawal and they cannot get into residential or outpatient services.
*MAT medications are harder to wean off then regular opioids.
*Cash cow to some of the providers prescribing as it's easier to dose than do treatment.

*Many MAT providers in state are unregulated and unsupervised, selling prescriptions in the Walmart parking lot in Dickinson, not requiring treatment, over prescribing to the point clients are in a zombie state and no follow up given, only by telehealth and no supervision.

* Peer Support – helpful but again, only a tool. Is only helpful in early stages of addiction with motivated clients and in the maintenance stage after formal treatment is completed.

Some officials are suggesting that "peer support" will take the place of Licensed Addiction Professionals. This is not helpful and untrue. They have limited training, and typically the clients are not invested, the reimbursement is not enough to sustain the positions. Agencies are having to supplement these positions from other areas. Huge liability risks!

*Clients need a full continuum of care. From prevention, outpatient, residential and aftercare services.
*It is suggested that more funding be put in prevention (absolutely) but what do we do with the client on the deep end until that shows effectiveness? We need to continue to treatment those with full blown addiction issues and offer them the opportunities to get well. We do not abandon people medically, why with behavioral health issues?

North Dakota continues to count beds, however there is no process to count needs of those unserved.

SPRC receives 5 to 12 calls a day of clients that are Sanford Expansion, Medicaid, Uninsured or with high deductibles that cannot find services anywhere in the state.

*Last Friday by noon we received 10 calls from people with these issues we could not serve.
*50 calls a week of unserved individuals, 200 a month, just from our agency and people do not even realize we are available.
*People are terrified.

*Typical addicted client.
*May Lack Transportation
*Is couch surfing.
*Cannot afford day care.
* Deep end clients typically cannot hold a job.
*Are not able to access Human Service Center's due to the style of intake (early morning, have to wait – denied and must return – they give up or are unable to secure transportation) Often forced into groups they don't want to be in that are not addiction related (engagement group – 5 or 6 weeks) prior to addiction group, they quit due to the lack of access, success and belief that someone cares, often turned away and referred to other agencies that will not serve them due to the level of care needed and low reimbursement from Medicaid/Sanford Expansion (frustrating and clients will not follow through – too hard)
*Recommendations are to low and not effective, no place to get help.
*struggle maintaining motivation to jump over the barriers.

Typical wait for residential if needed 4 to 6 weeks for people with regular insurance, 6 to 8 weeks for those with Medicaid/Sanford Expansion (if at all) only so many of these beds available due to IMD restriction. Regular insurance people are finding treatment out of state due to lack of services in state,

Arizona, Vegas, California, Florida are their favorites. North Dakota insurance monies are going out of state with no return. Due to not being able to connect with their families and having no after care plan they quickly relapse.

*Yesterday in group, 13 clients, 7 of them said if they weren't safe, they would have relapsed and left treatment because they were so uncomfortable (vomiting, diarrhea, muscle cramps, stomach upset, unable to sleep, tremors, temperature) All were on prescribed medications for withdrawal. What happens to those that do not have the safe environment to recover in? All have tried outpatient and MAT medication in past with no success or limited success.

Covid:
*Federal stats show 30% increase in use of fentanyl since shut down.
*Relapses in those sober/clean 10 and 20 years due to loss of employment, business shut down and not able to care for families.
*Many people were without insurance 60 days after shutting down and unable to secure Medicaid or Sanford Expansion of it they did there was a significant wait time.
*Voucher Disappeared
*Increases in overdose, suicides, other mental health concerns for individuals and families.

Unfortunate time to run out of monies when the need was the highest ever in the history of the United States and North Dakota

*Opioids quickly addictive – so very dangerous sometimes just days. Experimentation is so different with this drug than with alcohol and marijuana.

The poor who suffer, most are never able to receive services, particularly residential.
Even if people can take Medicaid and are within the 16-bed limit, they only reserve a few if any beds for Medicaid due to low reimbursement, delayed reimbursement or having to appeal the reimbursement decisions due to the handling of the claims at the state level.

Calls coming from ER Doctors, Nurses, Families, Ambulance personal but mostly: From the Human Service Centers – it is interesting that it is this agency that is indicating there is no need when they are desperate for placements and services for their clients.

Solutions/Suggestions:
Fund the voucher at is full proposal: Even this amount is not enough.
Propose an IMD Waiver: Cap the limit if you are concerned about too many beds or too much growth for any one agency.
Monitor/Require appropriate documentation to utilize the voucher (Initially when the voucher was proposed the state was not prepared and did little to monitor the financial need of those requesting services, thus some agencies were quick to capitalize with little accountability)

*Restructure Medicaid for that claims are processes and paid in a timely manner. Medicaid reimburses about ½ of other insurance payors. With this problem, no one wants to take these clients. Make it inviting to take Medicaid. When we call you cannot talk to a person, you are forced to email and then often there is no return message, people are rude and often times they do not know the rules, different people tell you different things. It is not uncommon that their website tells you the clients are eligible on a certain day and the services are provided and the checks for services issues only to be recalled because their website is no accurate. Thus, the agencies are not able to obtain payment for those services. Most private providers are not willing to do this or take the risks of serving these clients.