Senate Finance Committee Testimony 4/9/2024

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Thank you Chairman Cardin, Senator Daines and Members of the Committee for the opportunity to speak with you today and for your work on healthcare and ensuring all Americans get the healthcare they need. I am the Chief Behavioral Health Officer at Rimrock Foundation, a private, non-profit treatment center in Billings, MT. I am also the President-Elect of NAADAC, the Association for Addiction Professionals. I am here today to represent both organizations and provide a voice of advocacy for the people we serve and the stakeholders in our communities.

I'd like to take this opportunity today to share a little about what addiction is and why it is so challenging to treat, especially in rural and frontier states. My testimony will focus on a lack of continuum of care and our workforce. It is also important to recognize that, while rural and frontier states struggle, addiction and mental health are medical conditions in our metropolitan communities as well. Addiction is truly a public health crisis: its impact is felt emotionally, socially and economically. Even if you do not personally know someone who struggles with addiction, if you pay taxes, this problem impacts you.

I live in Montana: a predominantly rural state where healthcare, let alone mental health and substance use care, is often difficult to access. I have worked at Rimrock Foundation for 18 years in several roles. When I travel and speak at conferences and to people in other states, I am continuously amazed (and grateful) that I work at an organization that provides a full continuum of care. A client can come to Rimrock and receive medically supported detox services, inpatient, residential, day treatment, intensive-outpatient and individual counseling. We are also multi-disciplinary: we provide medical care through nurses and mid-level providers; mental health counseling; substance use counseling; peer support; case management; and medication-assisted treatment for those with alcohol and opiate use disorders. It's just the way we roll: we are small but mighty. Unfortunately, we are also somewhat of an anomaly. That a client can receive all those services from one organization is not the norm, but it should be.

The American Society of Addiction Medicine defines addiction as a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences" (ASAM.org; 2019). Specifically, addiction impacts the areas of the brain that help us weigh the rewards or consequences of behavior; this leads to behaviors that are destructive to self, other and society as a whole. A person's brain does not fully register the consequences of a certain behavior, particularly involving the use of their substance, for example, not recognizing the potential consequence of driving while intoxicated; not recognizing that Child Protective Services will take their children if they

use; or that their probation will be revoked if they leave treatment. For people with substance use disorder this results in increased interactions with criminal justice, healthcare and social systems that is simply not sustainable. However, unlike other primary, chronic illness', addiction is not easily measured or treated. Additionally, other illnesses are not plagued by the stigma that surround addiction.

Let me provide an analogy. If I break my leg and go to the emergency room, the multidisciplinary providers there are all trained and experienced on how to help me: a tech or med-aid will take me to the get an x-ray or CT scan; a radiologist will look at it; an orthopedist may consult; nurses will provide wrap around care. I will likely be advised to have surgery (with a whole new phalanx of multidisciplinary providers), physical therapy, crutches, etc. Additionally, I receive support from my community: my husband is able to drive me to work since I can't with my cast; my employer is willing to grant me time to go to my physical therapy and follow-up appointments; people are willing to hold the door for me in the grocery store and give me extra time to cross the street. For the most part, my treatment outcome is known. The providers can determine if my fracture will successfully heal or not and, if not, they can easily measure the lack of healing through additional x-rays. It is also obvious that, if we do not treat my fracture in a timely manner, I am more likely to have a less than ideal outcome or even have long-term problems with my leg. Additionally, the services provided are seen as the standard protocol for treating my fracture and are the expected course of care. For the most part, no one is going to argue that I need the care.

If I was to go into an emergency room with a broken leg, none of those providers would tell me "You have two legs—you are fine, just hop around!" Now, let's flip the script, when it comes to addiction and mental health, that is exactly what we do. This is, in part, because we do not have quantifiable ways to "measure" the severity of the brain malfunction: while brain imaging has been enormously helpful in getting us to understand the areas and functions of the brain that are impaired on a cellular and physical level, they are not diagnostic and are cost-prohibitive. While the DSM-5-TR and ASAM placement criteria have made huge strides in helping our diagnoses be more objective, it is still relatively subjective depending on the nature of the clinician (and addict) doing the assessment. As a disease of the brain, addiction is also incredibly complex to manage. The emotions, personality and daily functioning of a person with addiction are impaired, making their engagement in treatment an additional barrier. Very few people will deny that they have a broken leg, but people with addiction frequently deny the problem and minimize its severity.

When it comes to treating addiction, we essentially provide the acute care in the form of inpatient or residential treatment—your stereotypical 28- day program. If I follow my "broken leg" analogy, this is the surgery (and even then, sometimes insurance will not pay for the treatment...) but none of the follow-up care; we do not provide physical therapy, crutches or other assistance and the community often scorns the person. When the "fractured leg" (addiction), doesn't heal, we often blame the patient; we'd never blame someone with a broken leg that didn't heal because they couldn't access physical therapy or use crutches. But we often blame those with addiction for not engaging in treatment or following recommendations, even when there are often significant barriers to them accessing the care. As treatment providers, we are often only able to provide a few weeks of "phsyical therapy" even when clinicians and providers know that they need a few months instead of weeks. I often hear phrases like "I

guess they just don't want recovery" and "I guess they just don't care about their family or kids" and even "I guess that's one less junkie we'll have to deal with."

The integrated, outpatient continuum of care is imperative to ensuring the success of the inpatient/residential treatment. If I provide inpatient or residential care for a client with alcohol use disorder (including medically supported detox, addiction counseling, mental health counseling to address the underlying PTSD that drove the drinking in the first place, group counseling, life skills, medication to address alcohol cravings, peer support services) but do not adequately provide the outpatient continuing care, it is akin to doing surgery to fix a broken leg and then not providing physical therapy. Did I actually help this person or not? A true continuum of care allows for providers, either within their own organization or by partnering with other groups, to provide family counseling, mental health counseling, peer support services, medication assisted treatment and group counseling. We are also woefully behind in being able to provide prevention and early intervention: we've been able to provide surgery for the broken leg...but why are so many people breaking their legs? We must do a better job of prevention: we simply cannot "treatment" our way out of the addiction crisis.

In part, the challenges with a continuum of care is due to not being able to pay professionals appropriately. Issues surrounding our workforce have a huge impact on my ability to provide a continuum of care: might have an open inpatient bed, but do not have enough nurses to safely detox that person and I do not have enough counselors to put them into group therapy. Low rates of reimbursement, frustration at the poor systems of care, low wages, and a lack of regional medical schools make it challenging to not only build but retain a workforce.

Here is an example: In Montana, like many communities, we expanded Medicaid. This was a good thing as it allowed people that otherwise would not be able to afford care to receive it. The problem, however, is that the low rate of reimbursement for Medicaid created a black hole of budget constraints: you can literally Medicaid-yourself-out-of-business. Here are the numbers for my organization:

Service	Private Insurance	Medicaid	Difference
Medically Supported Detox	$1,1000 per day	$298.79 per day	$801.21
Residential (ASAM 3.5)	$900 per day	$256.95 per week	$643.05
Intensive Outpatient	$650 per day (4 days per week=$2,600)	$386.75 per week	$2,213.25
Outpatient Group	$22.20 per group	$17.91 per group	$4.29
Individual Session (60 minutes)	$120.46-$151.96	$98.34	($22.12-53.62)
Assessment	$155.00	$116.93	$38.07
Screening, Brief Intervention and Referral to Treatment (SBIRT)	$23.33 (30 minutes) $44.61 (60 minutes)	N/A	N/A

Medicaid pays 31.6% of what BCBS will pay for a residential/inpatient stay, and that's for 31 days (Medicaid) vs 28 days (BCBS). The total is $7965 for an entire residential stay (room and board and treatment – does not include detox or meds or ancillary services

To make this even more problematic, Montana has now started to redetermine Medicaid eligibility: many of our clients that used to qualify for Medicaid now do not. However, they also cannot afford or access health insurance through their employer. Now, they do not have any care and people that are struggling with substance use disorder cannot access care. Do we just let people hobble around with broken legs? Medicare has recently started changes to services and disciplines that it reimburses for, in the substance use continuum, I'm not sure how helpful it may be: Medicare does not pay for peer-support services and only addiction counselors with a master's degree and a certain amount of supervision are eligible. Most addiction counselors in Montana do not have a master's degree.

We must do more to support (and continue) to work on integrating services and systems of care. Addiction is a whole-person illness and impacts not only a persons' physical and mental health, but also their family and social behaviors; therefore, treatment must be about the whole individual. If I help you get sober, but do not help you address the underlying trauma that drove the addiction, did I actually help you? Or did I just take away the only coping tool you have? Rural communities are impacted to a greater degree than metropolitan areas simply because we may not have the services needed to treat the addiction; we also may not have the ability to be reimbursed for services. Most Third-Party Reimbursement programs, including Medicare, do not reimburse for Peer Support, a modality that we know provides an essential dimension of care. We simply cannot continue to silo our services. We will continue to have broken legs and blame people for not being able to walk.

Thank you for your time and attention.

Additional policy considerations/data points for policy makers:

For government funded funding sources: can we diminish the amount of paperwork? Medicaid requires more paperwork and documentation from me than any other funder. The state of Montana has issued me two licensed (as a Clinical Social Worker and Addiction Counselor) and I have numerous certifications that indicate I am competent, however, an insurance company (including Medicaid) may tell me that my patient does not really need the residential, inpatient, or outpatient care that I deem them to need. The utilization review process not only often creates a redundant cycle of paperwork, it takes time and energy away from providing care.

Geography is also a challenge: while telehealth has certainly made it more common place and accepted to receive counseling and medical care over a camera, not everyone in Montana can access the internet. A client may come to Billings for their inpatient or residential care but returning them to their community and still providing the wrap-around care they need (and that research tells us give us better outcomes) is near impossible. There simply is not this range of services in most of our towns in Montana. Many do not even have a licensed addiction counselor or mental health counselor in their community. Additionally, many of those challenged with addiction are in a socio-economically repressed

system and do not have the funds for a Smartphone or computer or unlimited data: one telehealth session may drain all their data.

Stats and statistics:

In 2021, there were 106,600 drug overdose deaths; 51% increase since before the pandemic

In Montana, overdose death rates have increased from 14.4 to 19.5 per 100,000 in 2011; in 2021, it rose again to 19.5 per 100,000; during the same time period in the United States as a whole, the rate increased from 13.2 to 32.4.

In 2000, 48% of drug overdose deaths were attributed to opioids; in 2021, they were 75%

(Mental Health and Substance Use State Fact Sheets: Montana | KF0F), CDC

Clearly, we have a problem with substances.

Suicide and mental health is also a significant medical problem.

According to the CDC, the suicide rate in Montana per 100,000 is 21.1 with a firearm in Montana (7.5 for the United States); suicide rates for non-firearm methods per 100,000 is 10.9 in Montana and 6.5 for the United States as a whole.

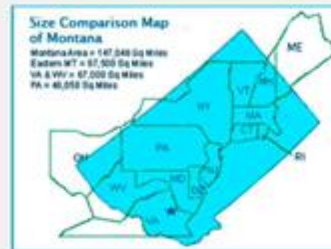
Our workforce is significantly lacking; only around 27% per cent of the need for healthcare workers is being met. Bureau of Health Workforce, Health Resources and Services Administration, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022. In May of 2022, 35.5% of Montanans that needed mental health care were not able to get it as compared to 28.2% for the United States as a whole (KFF analysis of U.S. Census Bureau, 2023).

One of our challenges with the SUD workforce is that we cannot pay a livable wage; this is, in part, due to rates of reimbursement. Montana is a Medicaid expansion state: while, in some ways, this has been an advantage in that it has allowed Montanan's that otherwise would not have healthcare to access it, the rates of reimbursement and far below sustainability. As Montana has rolled back (redetermined) Medicaid eligibility, many individuals that used to rely on Medicaid have found themselves without coverage. They are often unable to afford or access healthcare through their employer or the marketplace. Utilization of FQHCs and CCBHC's may be one way to expand services to other communities.

Montana Primary Care Association, 2024

Big Sky Country

- Geography: 4th largest state
- Population: 1.06 million
  - Cattle population: 2.55 million
- 45/56 Montana counties are frontier
  - Frontier: 6 or fewer people/square mile
  - 10 are classified as rural
  - 1 is classified as urban
- By comparison:
  - Vermont has 68 people/square mile
  - Maine has 43.1 people/square mile
- 7 reservations and a large American Indian populations (6.5% of population)
- By 2030, Montana will have more people over the age of 65 than under the age of 18



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