THE TRUMP ADMINISTRATION'S RESPONSE TO THE DRUG CRISIS, PART II

HEARING

BEFORE THE

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THE TRUMP ADMINISTRATION'S RESPONSE TO THE DRUG CRISIS, PART II

Thursday, May 9, 2019

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM
Washington, D.C.

The committee met, pursuant to notice, at 11:06 a.m., in room 2154, Rayburn House Office Building, Hon. Gerry Connolly presiding.

Present: Representatives Connolly, Maloney, Norton, Krishnamoorthi, Raskin, Rouda, Hill, Sarbanes, Welch, Speier, Kelly, DeSaulnier, Plaskett, Khanna, Ocasio-Cortez, Pressley, Tlaib, Jordan, Amash, Massie, Meadows, Hice, Grothman, Comer, Cloud, Gibbs, Higgins, Roy, Miller, Green, Armstrong, and Steube.

Mr. CONNOLLY. The committee will come to order.

The Chair is authorized to declare a recess of the committee at any time.

The full committee hearing is convening to continue our review of the Administration's response to the drug crisis. We previously held a hearing on March 7. This hearing is a followup continuing our examination of ONDCP's coordination of national drug control efforts, including efforts to expand access to treatment.

I now recognize myself for five minutes to give an opening statement.

Earlier today, members of our committee had the very important opportunity to meet with four extraordinary individuals who have lost loved ones to our Nation's crippling substance abuse problem. We heard from Mr. Kevin Simmers, Ms. Shauntia White, Mr. Bill Sternberg, and Mr. Mike Cannon. They told us about the challenges their families endured while trying to get help for their loved ones in their hours of greatest need. They turned their unbearable pain into an inspiring passion to help save other lives and spare other families from the terrible ordeal that they went through.

They are all here with us now, and I would like to ask each of them to stand and be recognized for their courage.

[Applause.]

Mr. CONNOLLY. Thank you so much. Thank you.

On behalf of this entire committee, we thank you for sharing your stories and for bringing the commitment you have and your dedication to this very important battle that affects all too many families across America.

I know your determination and urgency are shared by countless other families also struggling to help their loved ones, and thank you again for everything you have done and continue to do.

Today, the committee is holding our second hearing on the Trump Administration's response to the opioid crisis. At our first hearing in March, we heard testimony about the Trump Administration's failure to issue a national drug control strategy for two years while tens of thousands of people succumbed.

We also examined the unsatisfactory strategy that the Administration finally issued earlier this year in January, and we heard the Government Accountability Office testify that this strategy is deficient; in fact, did not really add up to a strategy, and does not comply with the basic legal requirements Congress has set.

The strategy or so-called strategy lacked enough detail for the committee or GAO to exercise even minimal oversight or to ensure accountability for the tens of billions of dollars we spend annually on national drug control efforts.

For these reasons, we told the Office of National Drug Control Policy they had to do better, and we told them that we would have them back today to gauge that progress since our earlier hearing.

The good news is that there have been some improvements. In response to the committee, ONDCP has now provided several supplements to the paper it issued earlier this year. These materials are certainly more useful than what we saw in January, and I thank Director Carroll and the dedicated public servants at ONDCP for the progress they have made.

Unfortunately, the goals in these documents are, to use the most charitable description, all too modest, especially in light of what we heard this morning at the roundtable. For example, there were approximately 70,000 overdose deaths in 2017. But the Administration's plan seeks to reduce overdose deaths by only 15 percent over five years. At that pace, more than 200,000 Americans will lose their lives between 2019 and 2022, even if ONDCP meets all of its goals. That is a frightening projection and one, I think, on a bipartisan basis, we cannot accept.

Here is another one. Right now, only about 10 percent of people who need addiction treatment can get access to it across the country. The Administration does have some ideas here. Its plan says, "Evidence-based addiction treatment, including medication-assisted treatment for opioid addiction, is now more accessible nationwide." But when you look at the details, the Administration's plan is to have only 20 percent of specialty treatment facilities provide this type of medication-assisted treatment by 2022. In fact, we know that most rehab facilities, in fact, are not medication-assisted treatment facilities, even though we know medication-assisted treatment is the only efficacious treatment for opioid addiction.

We must do better. We have to fight harder. The opioid crisis is the most devastating health emergency our Nation has faced in over a generation, and we need a bold strategy to meet this challenge head on.

That is why every Democratic member of the committee joined together yesterday to introduce the CARE Act, which stands for the Comprehensive Addiction Resources Emergency Act. This land-

mark bill would finally provide stable and sustained resources to expand treatment for those who so desperately need it.

The CARE Act has now been endorsed by more than 200 organizations, including the American Medical Association, the American Society of Addiction Medicine, the National Nurses United, the National Association of Counties, the March of Dimes, the American College of Physicians, and the AFL–CIO. It is supported by doctors, nurses, mental health experts, organized labor, local governments, public health experts, and tribal organizations.

The CARE Act will finally start treating the opioid epidemic like the public health emergency it is, and it will help people in red states, blue states, and purple states who are suffering without adequate access to treatment.

Opioid addiction does not know partisanship. These include people just like the loved ones and the family members who were lost by Mr. Simmers, Ms. White, Mr. Sternberg, and Mr. Cannon.

I want to thank you all again for being here, and we all look forward to what we hope is a more productive session this morning.

I now turn to the Ranking Member for his opening statement, Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

I, too, want to thank our guests and Director Carroll for coming back as well for a second time here.

Our country is a country that values community and civic engagement. It is now being devastated by drug dependency. It is a crisis that hits close to home for every single family, and it has hit especially hard for Americans like Ms. White, Mr. Simmers and Cannon and Sternberg, who are joining us today in the audience. I, like the Chairman, want to thank you for your story. The last hour we just spent upstairs hearing your story was so compelling. Thank you for bravely sharing your compelling experiences with us this morning, your stories about your loved ones, and all too similar stories felt by an Ohio family, the Riggs family, who lost their young daughter to heroin use at the age of 20. In the face of such grief, Ms. Riggs speaks with students and their families about her daughter's struggle to bring awareness and shatter stigma in hopes of preventing such devastation to other families.

Our home state of Ohio, over the course of a single year, witnessed almost 5,000 fatal drug overdoses, nearly 14 deaths in a single day. But this crisis does not strike each community in the same way. What prevention, treatment, or enforcement efforts may be effective in one area may not work in another. This is not a problem that funding alone can solve, even $100 billion. We need to thoughtfully empower each community to address its unique need to reduce drug supply, prevent illicit drug use and, most importantly, get the needed treatment for these individuals.

Sheriff Wayne Ivey is with us today from Brevard County, Florida. He is making great strides for his community. Sheriff Ivey, who relies on ONDCP for standardized and timely data about drug trends and emerging threats, recently led the arrest of nearly 100 traffickers of meth and nearly three pounds of fentanyl. That is enough fentanyl to kill every single person in this country.

But it was something else about Sheriff Ivey that struck me. Sheriff Ivey has recognized an important aspect of this cyclical cri-

sis. When those battling substance abuse disorders are climbing out of despair, they are in need of support; treatment, yes, but also purpose. Sheriff Wayne connects his inmates in jail for drug use with training and jobs on release into the community. Now the cycle might have a chance of being broken.

Under the Trump Administration, the strength of our economy is creating tons and tons of new jobs, good-paying, dignified jobs that can be filled by those who may have struggled with the drug problem. Lifting every single member of a community and giving them a job, responsibility, and accountability gives them purpose.

I look forward to hearing from Director Carroll, who leads the Office of National Drug Control Policy, a recently revitalized office that is playing a newly enhanced role in coordinating this effort. Director Carroll, the Chairman and I want your office to succeed. I look forward to hearing from you on the progress of ONDCP and the Trump Administration, and I remain optimistic about the support of the committee for continued progress.

I also look forward to hearing from the experts on the ground who battle this problem daily. Thank you all for taking the time to be here this morning to discuss this office and help us all find solutions to the public health crisis of our time.

With that, Mr. Chairman, I yield back.

Mr. CONNOLLY. Thank you, Mr. Jordan, and thank you for sharing that data on Ohio. It is gripping and disturbing and, unfortunately, not unique.

Mr. JORDAN. Not unique.

Mr. CONNOLLY. I know we have an opportunity in this committee, on a bipartisan basis, to move forward, and I certainly commit to you in wanting to do that.

Now we want to welcome back ONDCP Director James Carroll, as well as Triana McNeil, the Acting Director of Homeland Security and Justice of the Government Accountability Office. She is accompanied by Mary Denigan-Macauley, the Acting Director of Health Care at GAO. And I would also like to welcome Dr. Karyl Thomas Rattay—am I pronouncing that correctly?—the Director of the Delaware Division of Public Health and Safety; and Sheriff Wayne Ivey of Brevard County, Florida. I want to thank them all for participating in today's hearing.

It is our custom to swear in witnesses. So, if you would all rise and raise your right hand?

[Witnesses sworn.]

Mr. CONNOLLY. Thank you. You may be seated.

Let the record show that the witnesses answered in the affirmative.

The microphones are sensitive, so I would ask each of you to please speak directly into them when you turn on the button.

Without objection, your written statement will be made part of the record.

With that, Director Carroll, you are now recognized to give an oral presentation.

STATEMENT OF JAMES W. CARROLL, JR., DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY

Director CARROLL. Thank you, Chairman Connolly, Ranking Member Jordan, and members of the committee. Thank you for the opportunity to appear before you again to discuss the critical work the Office of National Drug Control Policy has been doing to address the challenges America faces from the opioid epidemic and the broader addiction crisis.

I want to especially thank the committee for their leadership on this issue, and I appreciate the invitation to return and have the opportunity to talk with you all about the work that has been going on since we last met.

It has been my pleasure since our last hearing on March 7 to bring the GAO into ONDCP to see the great work my team has been doing and making them familiar with our critical role. Moreover, I ensured GAO has received all of the supplementary information they requested from ONDCP, including 1,501 pages of documentation, in response to the additional request from GAO. I am incredibly proud of my team, and I believe our GAO colleagues have gained a great deal from the time they spent with the most senior members of my staff in meetings on at least 10 different occasions since our last hearing.

I would also like to thank the committee staff for joining us for several routine interagency engagements over the past month, which I hope gave them additional context for a few of the issues that were raised at the hearing.

The time since my last hearing has given us the opportunity to continue issuing the supplementary materials of the National Drug Control Strategy, as planned, that fulfill our statutory requirements. As we continue the process of formally implementing the 2019 Strategy, several of our interagency partners have provided us valuable positive feedback on its clarity, focus, and utility as the right framework to guide broad control activities in the years ahead.

In addition to the main Strategy document, its three companion documents provide valuable context on today's drug trafficking and use environment, and the means to measure our progress and effectiveness as we advance the Strategy going forward. These include the Budget and Performance Summary, which provides details on the drug control budget that supports the implementation of the Strategy and provides performance metrics for each drug control program agency; the Data Supplement, which provides more than 150 tables presenting data on which ONDCP relies to formulate, implement, and assess progress toward achieving the goals and objectives of the Strategy; the Performance Reporting System, which provides the goals and objectives for the Strategy; plus the two-and five-year targets and metrics for tracking progress and achieving them. All of these documents are the constituent parts of the National Drug Control Policy Strategy, and they have been submitted to Congress and posted on ONDCP's website.

I am proud to say that during this entire period, my team has been focused on delivering tangible results for the American people. We are tackling the addiction crisis head-on, and we are beginning to see results.

Since the beginning of this Administration, the total number of opioid prescriptions has declined 34 percent. The number of naloxone prescriptions has increased by 484 percent. Twenty percent more people who have a substance use disorder are now receiving treatment.

ONDCP's ad campaign, "The Treatment Box," just this week won a daytime Emmy for compellingly bringing adults face to face with the opioid addiction. More importantly, the campaign has over 1.4 billion impressions from 18-to-24-year-olds, and has 92 million total online views.

As a result of all of these efforts and others, preliminary data suggests that the total number of drug-involved deaths has stabilized and for the first time in decades might be beginning to decline.

As I discussed with you before, I have made saving lives the central focus of our efforts, and it is the true measure of success not only for the agency but for the American Government as a whole. Every one of us at ONDCP knows that saving lives is the only criterion that really matters, and we will continue to advance that mission as we go forward every day.

I appreciate the committee's ongoing interest in working with ONDCP on this issue, and I look forward to answering your questions today.

Mr. CONNOLLY. Thank you, Mr. Carroll.

Ms. McNeil?

STATEMENT OF TRIANA MCNEIL, ACTING DIRECTOR, HOMELAND SECURITY AND JUSTICE, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. MCNEIL. Chairman Connolly, Ranking Member Jordan, and members of the committee, I am pleased to be here today to discuss GAO's ongoing work on ONDCP's strategies and programs, as well as our prior work on treatment for people who misuse opioids.

When I was here in March, I made some key points.

One, in 2017, 70,000 people died from drug overdoses.

My next set of points related to ONDCP's 2019 strategy. Based on our preliminary observations, it did not include a number of requirements such as a performance measurement system to track progress and specific assessments to provide a baseline of illicit drug use.

Since that time, ONDCP staff have met with us without delay and provided some previously requested materials. ONDCP staff also met with other GAO staff to obtain information on best practices related to strategic planning and coordination. We have also met with a number of drug control agencies during the past few months, in addition to White House counsel, to discuss the opioid cabinet.

Moving forward, we will continue to conduct a thorough assessment of the documents that ONDCP recently published that they said, in combination with the Strategy, comport with the provisions of the 2006 statutory requirements. These documents include the 2019 Data Supplement, the 2019 Performance Reporting System, and the 2019 Budget and Performance Summary.

Can GAO say that these three documents, plus the Strategy, adhere to the 2006 statutory requirements? Not at this time. But we will include a thorough assessment and our own conclusion in our upcoming report. We are working to finalize our design and begin to draft our report. Before we do that, we still need some key pieces of information to ensure we can answer questions from the Congress.

For example, we have asked for the budget funding guidance that ONDCP provided to drug control agencies. We need this to understand how they certified budgets when there was no strategy.

We also have a forward-looking aspect to our work, and we will continue to look at how ONDCP plans to address the requirements set forth in the Support Act.

This is a two-part statement. So, the other part of GAO's statement focuses on prior work that we have done on MAT, medication-assisted treatment, for opioid addiction. It is a combination of therapy and medications. GAO has issued two reports on this, one in 2016, one in 2017.

In 2016, we reported that several factors, including the availability of qualified providers, could affect patient access to this treatment. In 2017, we found that HHS needed to establish measures to better determine progress toward goals. HHS has partially implemented this recommendation. Moreover, further action to measure the capacity of providers would help HHS determine whether patient needs can be met.

My colleague, Mary Denigan-Macauley, from GAO's health care team, is here to answer any questions that you have related to this treatment, and I can provide any further information on our ongoing work looking at ONDCP's efforts.

Chairman Connolly, Ranking Member Jordan, and members of the committee, this concludes my prepared Statement.

Mr. CONNOLLY. Thank you, Ms. McNeil.

Dr. Rattay?

STATEMENT OF KARYL THOMAS RATTAY, M.D., M.S., DIRECTOR, DELAWARE DIVISION OF PUBLIC HEALTH

Dr. RATTAY. Chairman Connolly, Ranking Member Jordan, and distinguished committee members, thank you for the opportunity to appear before the committee today.

State, territory, and local health agencies are on the front lines responding to the current addiction crisis. As Delaware's state health official for the past decade, and as a pediatrician and epidemiologist, I have witnessed many facets of this devastating, complicated, and evolving crisis.

We first sounded the alarm and declared our epidemic in Delaware in 2011. Our data showed a steady incline over the previous two decades, going from five overdose deaths in 1990 to 100 in 2009. Importantly, the epidemic is evolving. In 2009, nearly all our overdose deaths were due to prescription drugs. Now, illicit fentanyl and other synthetic opioids are the major driver of overdose deaths, causing 72 percent of the 400 deaths we experienced in our state this past year.

And behind these data are real people whose lives are forever changed because of this epidemic. Opioid addiction affects a wide

array of individuals, from high school athletes to blue-collar workers and highly educated professionals. Yet stereotypes about those afflicted with addiction still exist, and one of the greatest barriers to treatment is the stigma experienced by individuals with opioid use disorder. We must view addiction as a chronic health disease that affects the brain, and just like asthma or diabetes, if we apply appropriate evidence-based strategies, addiction is both preventable and treatable.

For example, in my state we have had the pleasure of getting to know Alyssa, who was struggling with opioid addiction. However, she accepted help when her baby was born. She has received treatment and recovery services and has been successful with the use of buprenorphine.

Also, through our home visiting program, we were able to provide the necessary supports so she could appropriately care for her newborn baby. Alyssa and her now three-year-old daughter are thriving.

Although we would all love an easy fix to address this problem, no single public health tactic or policy will end the opioid crisis. The complex nature of this epidemic and its broad, pervasive, and substantial impact on communities and society at-large justify a multi-pronged set of strategies and solutions. Preventing and identifying addiction, connecting people to evidence-based treatment and recovery services, as well as reducing harm are critical pieces to the multifaceted response required.

With that in mind, I would like to emphasize three key points today. Federal, state, and local governments must take a comprehensive and sustained approach to not only address the current crisis but we must focus upstream to prevent individuals from becoming addicted in the first place. We strongly encourage the committee to include primary prevention as a core component of opioid-related legislation moving forward. Any resources going to public health should not cap primary prevention efforts. We must have the ability to have flexible resources to meet the needs of our communities and the populations we serve.

No. 2, it is crucial for the Federal and state, working with local governments, to continue expanding access to evidence-based treatment. The ideal system is engaging, comprehensive, coordinated, high-quality, and person-centered. It meets people where they are in their communities and provides an immediate connection to treatment when they are ready, no matter the setting. It addresses mental and physical health, as well as social needs like housing and occupational skill development. It is constantly improving, using real-time data and evaluation to drive decisionmaking.

As it relates to treatment that will lead to recovery, I strongly urge Congress to approve legislation to modify the three-day rule. As an example, under the current rule a non-ex-waivered emergency physician who is providing care for an individual who has overdosed can only administer and not prescribe buprenorphine one day at a time for the purpose of relieving acute withdrawal symptoms while a person is awaiting admission into treatment.

The Association of State and Territorial Health Officials is deeply concerned that the requirements of the three-day rule are preventing providers from appropriately managing withdrawal, and

we are missing opportunities to successfully engage people into treatment. Our members have explored many alternative options, but we are told by Federal officials that the only way to address this is through legislation. I implore the committee to address this immediately.

In closing, we work tirelessly to save lives, but we must also work to improve the lives of people who are impacted by the disease of addiction, and we must do all we can to prevent addiction.

Thank you again for the opportunity to speak today.

Mr. CONNOLLY. Perfect timing. Dr. Rattay, thank you very much.

Sheriff Ivey?

STATEMENT OF WAYNE IVEY, SHERIFF, BREVARD COUNTY, FLORIDA

Sheriff IVEY. Mr. Chairman, Ranking Member Jordan, and members of the committee, my name is Wayne Ivey, and I have the honor of serving as the Sheriff of Brevard County, Florida. We have a population of almost 600,000 citizens and are blessed to be called the gateway to space, as we are home to the Kennedy Space Center.

I would like to personally thank you for allowing me to speak to this committee today in furtherance of our national strategy to combat the opioid epidemic.

Government's one and only responsibility is to protect its citizens, and this epidemic is without question the most impacting challenge law enforcement has faced for decades. For those that have been in this business for a while, we remember thinking that crack cocaine was the worst thing we had ever faced. Sadly, we were mistaken. This epidemic far exceeds those realities and without question will destroy our communities if we do not aggressively intervene without delay.

As has already been said, this epidemic has no boundaries and does not discriminate. This nationwide epidemic is having devastating effects on individuals, families, and entire communities. In fact, in my county alone, we have felt the devastation at levels that none of us believed possible.

Brevard County is one of three counties leading the state of Florida in overdose deaths. In the past 24 months, my community has lost 172 dads, moms, sons, daughters, husbands, and wives to opioid deaths. That is 172 members of our community who were taken from us way too soon.

As if that were not bad enough, that number grows to 300 in the past 48 months, and sadly over 650 in the past 10 years.

In addition to those we have lost to death, we have also had to consider the impact on families who now have a family member in jail because they targeted the addictions of others for their own greed.

Opioids are also coming at an enormous financial cost. In fact, the financial impact does not stop at government. It extends to entire communities, including a significant impact on health care and employment. Communities like ours are not only losing friends, family, and loved ones, which is the ultimate loss, but we have suffered a great financial burden due to this epidemic. The rising cost of medical treatment for those suffering addiction and overdoses,

for newborns born dependent on opioids, for counseling and rehabilitation, and for law enforcement and first responders, the cost of combatting this abuse, distribution, and death caused by this epidemic is significantly increasing every day.

As an example of that statement, I would offer to this committee that in 2018, the Brevard County jail had 3,737 inmates who required medical detox treatment while incarcerated in our facility for opioid addictions. In addition, my agency alone has expended well over $200,000 this past year in Narcan deployment and investigative costs relating to investigations of deaths and crimes. Just last week, our agency culminated one of the most significant single drug investigations in the history of our community, resulting in the issuance of over 100 arrest warrants for dealers of fentanyl, heroin, and methamphetamine. These killers known as white powder, brown powder, China white or black tar, are historically manufactured and refined in Europe, Mexico, and China, laced with fentanyl, and floated into the streets of our communities. The drugs in our investigation were being delivered to the organization from California, Las Vegas, and Georgia by car couriers and U.S. Mail.

As a result of that investigation, our agents, in partnership with the Drug Enforcement Administration, Central Florida HIDTA, the United States Attorney's Office, the Brevard State Attorney, and our Florida Attorney General, seized kilogram quantities of fentanyl, heroin, and methamphetamine. As our committee members are aware, fentanyl can be a threat to anyone who comes into contact with it, as it can be absorbed through the skin, eyes, or accidentally inhaled. It is 50 to 100 times more potent than morphine, and 30 to 50 times more potent than heroin.

The Drug Enforcement Administration estimates that there are approximately 500,000 lethal doses in a single kilogram of fentanyl. The Drug Enforcement Administration further estimates that a 2-milligram dose is lethal for most people.

Using that formula, the amount of fentanyl seized in our investigation was enough to kill every single resident of Brevard County. This epidemic is not isolated to Brevard but instead is impacting communities in the same fashion across our great Nation. That is exactly why we must address this epidemic collectively at the local, state, and Federal levels, as well as in partnerships with our health care providers and lawmakers.

Based upon my experience as a 39-year veteran of law enforcement, I believe that we have to take a multi-dimension approach to stabilizing and eradicating this epidemic. To truly protect our citizens, we must shield them with a bulletproof vest that is designed to protect each citizen. If you know anything about a bulletproof vest, it is layer after layer of material that, when woven together, becomes so strong it will stop a bullet or edged weapon. If one layer fails, the next layer is standing ready to intervene. This type of strategy will be paramount in ending this deadly threat to our Nation. If we take a single-dimension approach to this issue, we will not be successful. And let there be no doubt, we must execute our plan right now, before another citizen is taken from us. We cannot delay or we will be effectively writing off a generation eliminated by addiction, prison, and death.

As such, I believe that we should construct our bulletproof vest with the following layers: education and awareness; aggressive enforcement; partnership enhancement; enhanced prosecution and sentencing; life-saving tools; and compassionate care and rehabilitation.

In the interest of time, I included the substance of each of those areas in my written statement, and if you would like, I would be glad to share more detail.

Mr. CONNOLLY. Thank you, Sheriff Ivey. We know you and your colleagues are in the front lines of this battle as well. Thank you so much for your service.

The Chair now recognizes himself for five minutes of questioning.

Mr. Carroll, Director Carroll, the Trump Administration's Drug Control Strategy says addiction is a chronic medical condition that affects the brain by causing distinct cognitive, behavioral, and physiological changes; correct?

Director CARROLL. Yes, sir.

Mr. CONNOLLY. And the Strategy goes on to state, quote, "Increasing the availability of treatment services for substance use disorder will lead to a greater number of Americans achieving sustained recovery and reduce the size of the illicit drug market and demand in the United States." Correct?

Director CARROLL. Yes, sir.

Mr. CONNOLLY. And yet there is a significant unmet need, is there not, for treatment in the United States? According to the Strategy issued in January, your office points out in 2017 an estimated 20.7 million Americans age 12 or older needed treatment for substance use disorder, but only 4 million of those 20.7 million received any kind of treatment, and only 2.5 million received that treatment at a specialty facility. And, of course, we could add to that that many of those so-called "specialty facilities" with respect to opioids are not appropriate, the treatment is not efficacious. So, that number even overstates how many people got efficacious treatment, and that is from your report, which is really stunning data in terms of capacity and cost apparently being such important factors in people getting treatment.

Director CARROLL. Yes, sir. Thank you for the question. I think it is important to note a few things at the outset. Undoubtedly, there are millions of people—as we said, the estimates are 18 to 20 million people who have an addiction. Sadly, not all of them, only a few percent that actually recognize and accept the fact, and we heard about it this morning, are willing to go get treatment. That is the estimate that we talked about of the people who are willing to get treatment.

So, certainly, one of the things that we need to do is decrease the stigma to make sure that more people are willing to get treatment. Right now, the estimates are 10 percent or so of that 20 million even seek treatment. So, first off, we need to increase the number that are accessing treatment. That is one of the things that we have successfully been able to do.

You talked about effective treatment, and as I said in my opening statement, I am very happy to report to the public and to the committee the number of people seeking treatment in the last year-

and-a-half or two years has gone dramatically up. But you are right, it is not up as high as we need.

And the types of treatment—and we heard a little bit this morning from one of the parents—every individual is different. We have to recognize the relationship between a patient and a provider, and one of the goals of the National Drug Control Strategy is to increase the number of treatment centers that offer medication-assisted treatment, MAT, by 100 percent. At the same time, we do have to recognize, as we heard this morning, some people who have this addiction do want to go to a facility where it is total sobriety——

Mr. CONNOLLY. I am going to have to interrupt because my time is limited, but thank you, good point. If you read Dopesick, by Beth Macy, she points out that two-thirds of all the treatment centers for opioid addiction in the United States still do not allow medical treatment, other drugs to take you down. That is a sure-fire recipe for getting on heroin or something worse. It just does not work. The success rate is in the single digits with that kind of treatment.

What we do know is that the AA approach, go cold turkey, absolutely is life-threatening when it comes to opioid addiction. It might work for alcohol; it does not work for opioids. And that is why——

Director CARROLL. And—I am so sorry.

Mr. CONNOLLY. No, go ahead.

Director CARROLL. I mean, I could not agree more, but there are many patients who are suffering from an addiction to opioids who have found that MAT does not work, and they want to go to a 12-step method. We should just make sure that we do not force MAT on a patient. I think the doctor would understand this, and we heard this morning from a father. Again, let's find the right treatment for them.

Mr. CONNOLLY. We want to stay flexible, but we also have data.

Director CARROLL. Absolutely.

Mr. CONNOLLY. And we know that MAT works three or four times better than cold turkey, and there are real risks with cold turkey.

Real quickly, Dr. Rattay, you talked about people in your state, which has a little more than half the population of my home county, having 6,000 people who are not receiving treatment. Given the size of Delaware, that is a pretty stunning statistic in terms of what we are talking about here in terms of people being able to get treatment, having access to clinics and rehab facilities that are efficacious.

Dr. RATTAY. Correct. Although we have been able to increase the treatment capacity in our state, we know we are not where we need to be yet with treatment capacity.

But also, as the Director mentioned, engaging individuals into treatment is also incredibly important. So, one of our focuses in our state is using what we call reachable moments such as when somebody has overdosed, when somebody is involved in the criminal justice system, or when a mother has had a baby as three prime examples of when individuals are most ready to become engaged into treatment, and then engage them very quickly into a system that really meets their own personal needs.

Mr. CONNOLLY. Thank you. I hope we have a chance to pursue that.

Final question. My time is up.

Director Carroll, I understand you had a conversation with the Chairman of this committee, Mr. Cummings. Have you had a chance to look at the CARE Act being introduced recently, and any reactions to it you want to share with us?

Director CARROLL. First off, I would like to appreciate the bill itself in that it is very clear that we share a mutual goal of saving lives, and I think the bill speaks to that, and I would love to be able to work with you, Chairman Cummings, and the rest of the committee to make sure that we are doing so in a way that is the most effective and efficient way to get help to people. So, I commend the heart and spirit of this bill.

Mr. CONNOLLY. Well, I just want to say I hope we can work on this on a bipartisan basis, Mr. Jordan, because this affects every one of our states. The stories, tragically, are the same. It knows no socioeconomic boundaries. It respects none, and we have got to save lives. We have got to try to get quick, effective treatment and try to turn this around. So, it has to be done on a bipartisan basis, and it has to be done with the cooperation of the Administration. So, thank you for that reaction.

I now call upon the Ranking Member, Mr. Jordan. I think you want me to recognize the gentle lady from West Virginia. The gentle lady is recognized for five minutes.

Mrs. MILLER. Thank you, Mr. Chairman.

I would like to thank all of you all for being here today, and I particularly want to thank the families who came and talked to us during the roundtable. My heart goes out to all of you.

I also hazard a guess that there is not an individual in this room who has not been affected by addiction. If you are standing in the line at the grocery store, sitting in a pew at church praying with someone, a family member, we are all touched by addiction.

I have spoken to this committee before about the opioid crisis and the devastating effect it has had on my community. My hometown of Huntington, West Virginia is considered the epicenter of the crisis, and I must give out my respect and heartfelt gratitude to my mayor, my fire chief, my police chief, all of those first responders, the faith community, and anyone who is in recovery, because we are all working together to solve this problem.

I have visited hospitals and centers where babies are treated because they have been exposed to addiction. They are not considered addicted. They are exposed to drugs. I have seen them laying inconsolable, writhing in pain and crying. It is a terrible thing. I have sat with their mothers who are being treated while they are trying to restart their lives. I have talked to teachers and principals who are now dealing with young people in school who are the result of the opioid addiction, and we are learning that teachers have more issues that they have to deal with with these children.

Addiction is heart-wrenching. It is a minute by minute, hour by hour struggle for those who have lived with it and face it every day.

I was pleased recently that the Huntington Police Department reported that they saw a drop of 60 percent in the heroin seizures between 2017 and 2018.

What is alarming to me is recently what we have seen is that the seizures of meth are up. They were up 366 percent. That number is alarming. Regardless of how many grams are seized, we have to recognize that trend is going on and that meth is also on the rise.

Huntington as a community has come together and has implemented some amazing programs to help those struggling with addiction, to assist their families and respond quickly to the overdoses. There is no silver bullet. We need to focus on treatment for those who are struggling with addiction and stop the flow of drugs once and for all.

Director Carroll, the Justice Department recently charged 60 doctors, pharmacists, and others in opioids pushing through Appalachia. The case involved more than 350,000 prescriptions, encompassing more than 32 million pills.

This is unacceptable. How can we work together to prevent problems like this?

Director CARROLL. Thank you very much. I do want to commend you and the work that is going on in Huntington. You mentioned the mayor and the fire chief, and it is hard not to ask people to watch the documentary on Huntington of "Heroine," with an "e" on the end. It is a very compelling story to watch.

In terms of the prescriptions, we have, working hard with HHS, cut down on the number of prescriptions. But importantly, one of the things that we are developing is a National Prescription Data Plan to make sure that there is insight not only for physicians when they write prescriptions but also for law enforcement when they are out there, to make sure that they can see spikes and trends in terms of where a particular community is seeing a sudden spike in the increase of prescriptions being written and making sure that that does not trigger a red flag that we might have one of those 60 physicians or health care providers.

In reading the charging documents for those 60 individuals, it is horrifying. These are the people that we talk about who are preying on people with an addiction, asking them to do horrific things, knowing that they need the medication to sustain their addiction. So, I was very happy to work with DEA, as well as the state and local members of our High-Intensity Drug Task Force that participated in making sure that we are getting help to people through appropriate physicians, but we are not hurting them either. Thank you.

Mrs. MILLER. Mr. Chairman, may I ask for a few more minutes, please?

Mr. CONNOLLY. The gentle lady's time has expired. It may be possible when we come back that somebody could yield you some time.

I now call upon the gentle lady from the District of Columbia, Ms. Norton, for five minutes.

Ms. NORTON. Thank you very much, Mr. Chairman.

I want to thank all of the witnesses. This is critical testimony, especially after the roundtable we had. We just held a hearing with families of victims.

On the one hand I must say, Director Carroll, I am pleased that the Administration, after two years without a specific strategy, has developed since January a strategy so that the budget will enable a strategy.

So, if you look at first glance, the President's budget appears to put a priority on public health priorities. But if you take a second look, and you had better take a second look very quickly, you see that the President has very inconsistent policies here. He is gutting the very programs that are critical to the objectives of confronting the opioid epidemic. I say that because so many of those caught in the opioid epidemic depend upon Medicaid, four in ten adults struggling with this addiction. Indeed, we find that those struggling with this addiction are more likely to be on Medicaid than on private insurance.

So, I am trying to find the real deal on the resources that are committed to this program, and you have $1.5 trillion in Medicaid cuts over the next 10 years.

So, let me ask you, because I noticed something in your testimony, Dr. Rattay, in which you said that Medicaid had been critical to allowing individuals to get access to treatment, and that the expansion allowed the state—and I am quoting here from your testimony—"to free up treatment dollars to increase treatment capacity, including wrap-around services."

So, I would like to ask you, since we only look at one part of the policy without looking at what we are actually doing, let me ask you, Dr. Rattay, what would it mean in your own state if Medicaid expansion were repealed? How would this affect your ability, the ability of your state, to respond to the opioid epidemic?

Dr. RATTAY. Thank you for that question, Congresswoman. Having access to effective treatment is so critical to turning this crisis around. And as you mentioned, in our state expanding Medicaid has been, we believe, a critical piece to not only increasing access to individuals who are Medicaid recipients but also allowing us to use those additional state dollars to be able to expand capacity or support wrap-around services, as well as paying for peer recovery coaches, which is also an important piece to addressing treatment as an individual. Additionally, Medicaid has been at the forefront for allowing naloxone and buprenorphine to be available in our state.

So, going backward and reversing the expansion I believe would be incredibly detrimental, and probably we would—I should not say "probably." We would lose lives because of that.

Ms. NORTON. What if the Medicaid program were converted to a block grant with a per-capita cap? How would that affect what you are doing now, and what would be the effect in Delaware?

Dr. RATTAY. I do not oversee the Medicaid program in our state, and I do not want to answer for our Medicaid director, and I would say it really depends on the amount in that block grant. Flexibility can be a good thing, but if from a dollar perspective that limited——

Ms. NORTON. What about a per-capita cap?

Dr. RATTAY. Again, it depends on the amount. If the amount is too low——

Ms. NORTON. So, you have no cap now. There is no cap now to what you can spend with someone who has this addiction.

Dr. RATTAY. Right. I mean, we do all we can to take a person-centered approach, and since everyone's journey is different, some individuals do great on outpatient therapy, some require more intensive treatment. So, a cap could be very detrimental to appropriate treatment.

Ms. NORTON. Thank you, Mr. Chairman. I just want to say that you cannot begin to help somebody and then say, "I'm sorry, we have reached the limit of what we can spend on your addiction." Thank you very much.

Mr. CONNOLLY. Well, I would also just note your question about block grants. It depends on the size of the state. Delaware has three counties. My state has 95, and the suburban/urban counties in a block grant system that goes to the state capital always get the short end of the stick. So, it really depends on how big the state is, maybe, how you view block grants.

The gentleman from Kentucky is recognized for five minutes, the other gentleman from Kentucky.

Mr. MASSIE. Thank you, Mr. Chairman. I am going to yield my time to the gentle lady from West Virginia, who represents Huntington, West Virginia, the city where I was born and where a lot of my family reside.

Mr. CONNOLLY. The gentle lady is recognized, and I would just say to the gentle lady I am sorry I could not accommodate her request, because I know she was on a line of questioning, and we will restore the full five minutes to the gentle lady from West Virginia.

Mrs. MILLER. Thank you, Mr. Chairman. And I thank the gentleman from Kentucky.

Director Carroll, quickly, how is the approach to tackling the rise in meth in the United States different from addressing heroin or opioids?

Director CARROLL. One of the things, I think, it is important to remember as we were talking at the beginning of this hearing about medication-assisted treatment, I think we need to put the marker out there that, sadly, right now there is no MAT for people who have a meth addiction. And some states—when I was in Oklahoma a few weeks ago, Oklahoma has just been ravaged by meth. California is also hit particularly hard. There are a lot of rural places where methamphetamine really is on the rise. So, MAT does not work for those individuals.

One of the things that we need to do is to stop the flow of meth coming into this country, and it is all coming in from Mexico. The vast majority used to be made here in the United States. Through our law enforcement efforts such as Sheriff Ivey and the Drug Enforcement Agency, they have done a great job in stamping out the meth that was being made here. Since that time, it has been moved to Mexico. The purity of meth coming across the border is at an all-time high, 90-some percent. And meanwhile, because it is flowing into the country, it is less than half the price.

Mrs. MILLER. Okay. Thank you very much.

Sheriff Ivey, in my state we have had great success working with HIDTA, and I would like you to speak on your experience in working with the ONDCP and its program. How is it working in your county?

Sheriff IVEY. It is working very well. We have a great relationship with the Central Florida HIDTA Task Force. In fact, they were deeply embedded in this last investigation that we just conducted.

One of the things that I think makes that task force work so well is that the governing committee of the HIDTA Task Force is people such as myself that sit there and understand what is happening in that particular region. The data that we continually get from ONDCP is paramount in us being able to do what we do, understanding the trends that are taking place, understanding the intelligence from other aspects or other areas of the country.

So, everything, where we sit right now versus where we previously were on this epidemic, I think, is working, certainly in partnerships. I am a big believer—I always tell everybody there are all sorts of ships in the ocean, but nothing calms rough seas like partnerships. We have a great partnership with HIDTA. We have a great partnership with ONDCP. We could not do what we are doing, boots on the ground, without them.

Mrs. MILLER. Is there more that you see that they could be helping you with?

Sheriff IVEY. At the surface, not for us. We are getting everything we need. Obviously, all of us would like to have more fiscal input to help us with these issues and combatting it because of the investigative cost. But from an intel perspective, from a resource perspective, even to the relationship we have with the United States Attorney's Office in prosecuting these cases and making sure that we are keeping those who are preying on the addictions of others off the street where they cannot do that, it is working.

Mrs. MILLER. Thank you very much.

Mr. Chairman, I yield back the rest of my time to the gentleman from Kentucky.

Mr. MASSIE. Thank you, Ms. Miller. Thank you for being a leader on this issue. Thank you for representing my family there in West Virginia, and for taking this issue up for our region. As somebody who represents eastern Kentucky, we are all interconnected there in southern Ohio and West Virginia. So, I appreciate very much what you are doing on this, and I yield back the balance of my time.

Ms. HILL.[presiding] Thank you so much.

I would like to recognize Mr. Sarbanes for five minutes.

Mr. SARBANES. Thank you, Madam Chair.

I want to thank the panel for being here, and I want to also thank those who came and spoke at the roundtable earlier for sharing your stories, which I think had a tremendous impact on us.

Mr. Carroll, I want to thank you for coming and thank you for your Office putting forth the nine priorities now in terms of the goals for addressing the opioid crisis. Among them is the goal of increasing the percentage of Federal prescribers who undergo continuing medical education on prescribing practices, getting that up to 50 percent by the year 2022, which I think is a good goal. Cer-

tainly, those providers need to be informed on the most up-to-date education information, so their practices are safety-driven and evidence-based.

We should be nearing those safety standards, I think, as well in other aspects of our Federally-driven policy when it comes to the opioid crisis, and I am concerned that is not happening with respect to these high-dosage opioids. So, I wanted to discuss that with you for a moment.

The CDC's 2018 guidelines for prescribing opioids state that clinicians should avoid increasing dosage to what is called 90 morphine milligram equivalents, MME, a day, or over. So, that is the standard, 90. Despite that, FDA has approved opioids that exceed this limit. Let me give you an example. Oxycodone, the generic version of OxyContin, is available in immediate-release 30-milligram tablets. This form is FDA-approved for use every four to six hours. So, in other words, the FDA has approved a frequency of dosage which, in combination with what that dosage is, means that a patient following that prescription and taking four of those tablets a day is actually consuming 180 MME per day, morphine milligram equivalents per day, which is double what the CDC is recommending.

So, I guess the question is, as we are warning prescribers to avoid prescribing over these limits, does it not make sense that we also kind of look at what is happening at FDA in terms of that approval and whether that approval needs to be revisited with respect to these high-dose opioids?

Director CARROLL. Thank you for the question. Quite frankly, you are absolutely right. We need to take a hard look at what is allowable and recommended in terms of what we know about the impact it can have. We know that opioid prescription for someone who is taking a high dose in a week or less can become addicted. So, when we are going forward and making these prescriptions, or going forward and talking to doctors about this, we have to work with the health care experts to determine what is the right amount of dosage.

One thing, though, I want to make sure we keep in mind, and I hear it from the community quite a bit, are those people who are suffering from chronic pain. We want to make sure that they continue to have access, whether it is for a physical condition, or whether it is for cancer or some other life-threatening disease. We want to make sure that we are not stigmatizing them or making it harder for them to get their pain medication.

But you are right, we are trying to work together to make sure, and we are evaluating the pain management actually as we speak.

Mr. SARBANES. I appreciate that answer, and I do take your point that we need to strike the right balance. We want to make sure that there is the opportunity for physicians to prescribe pain medication in those instances where that is really the alternative option that is available to deal with that chronic pain situation. But I think there is going to be emerging evidence, as we look harder at this question of the high-dosage opioids, that the availability of that in combination with what the FDA prescribing limits are can create situations and potentially frequent situations where the dosage that that patient or that consumer is taking is well be-

yond what is actually needed to address the particular pain and make sure that that therapy is working.

So, I am very interested in pursuing better alignment of the CDC guidelines with respect to what is considered safe in dosage over a 24-hour period, aligning that with what the currently FDA-approved prescribing and dosage levels are. So, we hope to work with your office on that going forward.

Director CARROLL. I am happy to, and I am happy to have some of our pain experts and health care professionals work with you and the committee staff going forward.

Mr. SARBANES. Thank you.

I yield back.

Ms. HILL. Thank you.

I recognize Mr. Roy for five minutes.

Mr. ROY. Thank you, Madam Chair.

I appreciate you all taking the time to be here and visiting with this committee, and for all the work that you all do to address this particular problem. I appreciate everybody who is coming here and people who have been affected by this dreaded crisis that we face in dealing with the opioid epidemic.

A question for Director Carroll. I have a study here in the Journal of American Physicians and Surgeons from the spring of 2018, so a year ago, estimating the actual death rate caused by prescription opioid medication and illicit fentanyl. What the author, John Lilly, posits is that, from his closing: "As more constraints are placed on legal prescriptions, it appears that market competition is driving opioid misusers from prescription opioid medication to illicit fentanyl because of its high potency and the variability of dosing of legally obtained drugs. Illicit fentanyl is far more likely to result in death."

Would you agree with that characterization?

Director CARROLL. Thank you for the question. I think we do have a careful balancing here. One of the things that we need to do to address it is to make sure that we are not starting down that path of prescribing opioids when a patient does not need it. That is one of the goals, to reduce opioid prescriptions. The goal was a third by four years. We are actually already ahead of schedule on that.

The other thing that we do need to keep in mind is the education that we are doing in the communities through our Drug-Free Communities and with our partners to make sure that we are getting the message out to people——

Mr. ROY. But would you agree that a significant amount of the problem right now is illicit fentanyl?

Director CARROLL. Is illicit fentanyl? Absolutely.

Mr. ROY. Yes, illegally obtained illicit fentanyl.

Director CARROLL. It is terrifying. HIDTA last year alone removed a ton-and-a-half of fentanyl alone, which we heard how deadly it is.

Mr. ROY. So, without objection, I will ask that this report be introduced in the record.

Ms. HILL. So, ordered.

Mr. ROY. A graph that is in there is hard to see because I have not put it up, but you will see if you look at this, the blue being

the prescription opioids and the red being the illicit fentanyl. This is only through 2016. You will see some pencil chicken scratch on the right, my numbers looking at 2017. This shows upwards of—these numbers here take you to 35,000 almost total deaths as a result of overdose. That red number, that red being the illicit fentanyl, seeing the spike that we are seeing from 2013 to 2016, that number is progressing. Would you agree with that?

Director CARROLL. It is progressing and it is terrifying. That is one of the reasons the President has made it a goal to stop the flow of fentanyl from China. We got an agreement from the President. Now we have to enforce it and we have to make sure it is not coming through the mail or across the border.

Mr. ROY. Great. Would you, Director Carroll, or maybe Sheriff Ivey could jump in, would these data points make sense to you? According to Border Patrol's most recent data through the end of April, they have seized 136.09 pounds of fentanyl between ports of entry since October, 98.9 percent of that being seized on our southwest border. Does that sound like an accurate statistic to you?

Director CARROLL. Could you repeat the number again? I am just looking to my page.

Mr. ROY. Sure. This is data released for April, 136.09 pounds of fentanyl between the ports of entry since October. This is according to CBP yesterday.

Director CARROLL. That is correct, essentially what I have. I do not have April, but I have March.

Mr. ROY. Through March, okay, sure, 98.9 percent of which was seized on our southwest border. Does that sound correct?

Director CARROLL. Absolutely.

Mr. ROY. In Fiscal Year 2018, the United States Border Patrol seized 388 pounds of fentanyl, and this year's numbers are following a similar trend. Fentanyl is a powerful opioid, as you know. It is 50 to 100 times more potent than morphine. Is the flow across our southern border a significant portion of the problem that we are dealing with with narcotics in our country?

Director CARROLL. Absolutely, positively, without question. And I think all you have to do is actually go back to the data from 2017.

Mr. ROY. Right.

Director CARROLL. It was 181. Now in 2018, in the data we have for 2018, it is right, as you said, at 388. It is doubling. It doubled in a year. This is where it is coming from in terms of Mexico, and it is coming from China either directly from Mexico or through the mail. But the southwest border between the ports of entry is terrifying.

Mr. ROY. And are we aware that a significant reason that this is happening is because of the influence of cartels at our border? They are profiting by moving people and moving narcotics; true?

Director CARROLL. Absolutely. I will try to be quick. The drug cartels, they are an incredibly dynamic, organized group. These are not individual people out there. If you go down to the border, you will see forward scouts on the Mexican side with binoculars. They see where CBP is, they flood the zone with immigrants until CBP is preoccupied with individuals. Once they know CBP is over here with these immigrants, they flood the zone with the drug trafficker.

Mr. ROY. And I have 12 seconds left. Would the opioid epidemic be further enhanced in our country, improved, if we were to target cartels and stop the flow across the border and secure our southern border?

Director CARROLL. We absolutely—that has to be one of our many, but has to be one of the priorities.

Mr. ROY. Thank you.

Ms. HILL. Thank you.

I recognize Ms. Tlaib for five minutes.

Ms. TLAIB. Thank you so much, Chairwoman.

I wanted to personally thank the families from this morning. It was incredibly powerful to hear what the human impact of doing nothing looks like. I talk about that a lot, and I talked to Mike Cannon, Kevin Simmers, Bill Sternberg, and Shauntia White. Thank you again so much for sharing. I heard this sense of urgency from all of you of really having us do something.

So, Director Carroll, you have been very clear that we cannot end the epidemic without expanding treatment to those individuals suffering from the disease of addiction, and the National Drug Control Strategy recognizes, quote, "Addiction is a chronic medical condition."

I could not agree more, and what I heard this morning, it really was a testament that they do not want any more talk. They want to talk about the need for treatment and that we must dedicate resources to expanding those treatments. And then we have to make sure that it is actually working.

The Performance Reporting Supplement recognizes that in 2017 only 10 percent of specialty treatment providers offered medication-assisted treatment. However, the Administration sets a very modest goal of doubling the number of specialty treatment facilities within five years. Even if we reach that goal by 2022, only one in five specialty treatment providers would offer the medication-assisted treatment, and the vast majority still would not.

Director Carroll, how was this goal chosen? Why did your agency aim for only 20 percent when 70,000 Americans are dying each year from overdoses?

Director CARROLL. Thank you, Congresswoman. I would love to have that number be 100 percent. I think you would, too. And I think that is what the American people deserve. But what we are trying to do is—and we could put that in the strategy document, but what we have to do is set aggressive goals that we think we can actually meet once we have an understanding of what is going on.

This crisis, sadly, took us years to get here. There is a recent Washington Post article that talked about how long and how many years we could see this coming. I think we have to be realistic with people to say how long it is going to take to get us out of this crisis. That is why we have to rely not only on——

Ms. TLAIB. But it takes a strategy, Director, and——

Director CARROLL. We have a strategy. Yes, ma'am.

Ms. TLAIB. I know. Well, then tell me how many more people with opioid use disorder will be receiving medication-assisted treatment.

Director CARROLL. What we want to be able to do is double that number as quickly as possible.

Ms. TLAIB. What is that number?

Director CARROLL. Right now, the number of people receiving treatment is about 10 percent of the 20 million who had it. We do not have it broken down by specialized treatment. That is not the way HHS tracks the number in terms of facilities that provide MAT, but I am happy to try to work with you to get that HHS number, if they provide specialized treatment.

Ms. TLAIB. We know that addiction is a chronic disease, like diabetes. If only one in five diabetes clinics offered treatment with insulin, would that be acceptable?

Director CARROLL. I am not a health care professional, so I cannot tell you about diabetes.

Ms. TLAIB. But the point is, right, Director, that——

Director CARROLL. The point is that people are individuals, and we have to treat them as that and not raw numbers.

Ms. TLAIB. But we already know medication-assisted treatment is one of those elements that needs to be fully funded and the resources available to the families that need this.

Director CARROLL. I could not agree more.

Ms. TLAIB. So, I want to turn for a minute to the President's budget, because we cannot reach these goals without dedicated Federal resources. For my colleagues, it always will take resources, no matter how much we try to fix border issues. It is here now, and we cannot fix it without resources.

So, Director Carroll, what resources are needed to reach the Administration's stated goal of doubling specialty treatment centers offering, again, medication-assisted treatment within five years?

Director CARROLL. The President's budget included an additional $6 million last year, and I appreciate Congress' and this committee's support of getting additional treatment. The total budget that we spend on this issue is about $35 billion. And everyone—maybe not everyone, but a lot of people have the misconception that the vast majority of that goes to law enforcement interdiction attempts. It is patently untrue. It is almost a dead-even split of half of that money going toward law enforcement and interdiction, and the other half going to prevention and treatment, with 90 percent of that $18 billion going for treatment alone.

I appreciate the committee's interest in making sure that those treatment centers have the resources to get help to people.

Ms. TLAIB. So, as a member, and a new member, which agency is going to be responsible for achieving this objective?

Director CARROLL. That is part of the implementation process now, to work with the agencies. Obviously, at the end of the day, HHS on the treatment side has the largest part of that. But one of the things that we also have to remember is we have to have fewer people addicted in the first place to make sure we are cutting down on the availability of prescriptions, illicit drugs, and God willing we will have fewer people that are addicted. So, it really is—we cannot look at this too much in isolation, but obviously on the treatment side alone, the key partner for that will be HHS.

Ms. HILL. Thank you. Your time is up. Sorry.

I would like to recognize Mr. Higgins for five minutes.

Mr. HIGGINS. Thank you, Madam Chairwoman.

Ladies and gentlemen, thank you for appearing today.

I believe we face a cultural crisis in our country, and one of the major impacts of that crisis is an opioid challenge. A cultural crisis requires a cultural response, so let's talk about the genesis and the direction of this epidemic.

A decade ago, as a patrol officer, part of my job in communicating with the citizens that I served was greeting new residents, and I will briefly advise of one story that ended tragically because of prescription opioid addiction.

A lady moved into the neighborhood with her daughter, a young adult who had a child. So, the lady, her daughter, her grandchild moved in, were very happy. They were greeted by the community, and over the course of one year I watched this life deteriorate. The daughter left. The lady went from being very friendly to being rather mean and very aggressive, continually had her lights turned off, complaints from neighbors, et cetera, constant interaction from law enforcement, and my observations were that she was addicted to Lortabs.

We warned her. I told her. I said one night I am going to get a call here and you are going to be gone, from your daughter, your granddaughter. And indeed, that is exactly what happened. About a year after they had moved in, we got a call from the daughter that she had not talked to her mom in a couple of days. She had moved out some time before but she was worried; would I go check? I went and found the lady deceased with empty bottles of Lortabs next to her.

The Nation responded to this by restricting easy access to Lortab prescriptions and other opioid prescriptions, cracking down on doctor shops, et cetera, and this was largely effective. At the same time, our Nation was dealing with crystal meth. You remember, Sheriff, we had crystal meth labs, shake and bake labs, home labs all over the place. The Nation responded by restricting access to the primary ingredients of crystal meth, Sudafed, et cetera, took it off of the shelf and the aisles. You had to document who was buying this stuff.

So, the Chinese created fentanyl. A decade ago we were not dealing with fentanyl; now we are.

So, my concern is that this body looks beyond our actions and stays ahead of the curve of what can happen with the drug trade and the consumption of dangerous narcotics by our citizenry.

The flow of drugs across the southern border, to me the biggest thing we can do to fix this thing is to secure our southern border. With all due respect to my colleagues that have alternate opinions, I respect their opinions, but as a former cop I am going to ask you, Sheriff, if you would share with us, what would your jurisdictional authority look like? How would it impact Florida if we could just stop the flow of illegal drugs across the border with aggressive law enforcement and change in our laws?

Sheriff IVEY. Well, I do not think there is any doubt that securing our borders is going to not only impact this in controlling this epidemic but also impact us in the gangs, in the gun running, everything else that goes along with that. We work very closely with

our partners from ICE and just recently partnered with the 287(g) Program in Brevard County to be able to help in that aspect.

I can tell you that in working closely with them, we see the information, the data that Director Carroll was talking about earlier, the massive amount that is flooding into our country and that ultimately floods to communities like mine. It lands in communities where you are from, and that——

Mr. HIGGINS. Regarding those numbers, not to interrupt but my time is short, did 400 or 500 pounds of fentanyl last year, 100-something pounds thus far this year—I think those numbers are light, don't you?

Sheriff IVEY. I do. I believe those numbers are—the numbers that we actually——

Mr. HIGGINS. In my remaining time, would you respond, sir? Would there be positive ancillary impact if we could stem the tide, if we could hold this—would there be positive ancillary impact by being able to devote your assets to other services for your community, as opposed to——

Sheriff IVEY. Without question it would do that, it would have that major impact, and it would give us the ability to further our investigations in other areas.

Ms. HILL. The gentleman's time has expired.

Mr. HIGGINS. Mr. Carroll, yes or no, is the President serious about this?

Director CARROLL. Yes, sir.

Ms. HILL. The gentleman's time has expired.

Without objection, a study from the American Journal of Public Health, entitled "The Affordable Care Act: Transformation of Substance Use Disorder Treatment," is entered into the hearing record.

Ms. HILL. And I would like to recognize Mr. DeSaulnier for five minutes.

Mr. DESAULNIER. Thank you, Madam Chair and Ranking Member. Thanks for having this hearing.

I would like to ask my questions from the perspective, given that all of us participated in the amazing testimony—I believe all of us. Maybe, Ms. McNeil, you were not there; maybe you were—of Mr. Steinberg, Ms. Simmers, Ms. White, and Mr. Cannon, all of who are still here.

So, both professionally and personally, having heard what they said and having negotiated similar personal issues and tried to see them from a professional standpoint at the county and state level in California, and now at the Federal level, for multiple generations in my family, I have watched AA and now neuroscience and behavioral health, and I am going to direct the question first to Dr. Rattay.

But for family members, and we heard this from a journalist, a police officer, someone who struggled with the social service safety net, it very much resonates with me. So, I have heard family members take the approach to parents, to children, siblings, you need to do this, you shall do this, sort of the hierarchical "We can just say no."

Well, we know the neuroscience, we know the behavioral health, and that is not the right way to get a return on investment, and it is nice to hear a bipartisan "let's do evidence-based research and

have really good outcomes," and the GAO, I think, has done a marvelous job at trying to establish that. I am reminded of that quote often used, supposedly attributed to Einstein, that the definition of insanity is approaching a difficult-to-solve problem the same way and expecting different results. This, to me, is the epitome of it.

So, why can we not be more client-based, taking the evidence-based research—I do not know why we do not just give this to the Centers for Disease Control. This is what they do, with all due respect to Mr. Carroll. We had this conversation last time. To be perfectly honest, Kaiser in my area, in Walnut Creek, California, has an opening for substance abuse director. They have over 400,000 clients in my county. You would not qualify from a paper standpoint. So, I appreciate your passion. The National Institute for the study of cancer—I am a survivor of cancer. The NIH's evidence-based research to develop the directors.

So, my point is client-based, but then have professionals develop the evidence-based research.

In your experience, do family members in Delaware go through what family members in California and what we heard this morning? And how can we help the family members get the resources they need given the urgency? I think the testimony by the police officer was amazing. I mean, how many times does a family have to spend that kind of emotional and mental strain to get through the bureaucratic process?

Dr. RATTAY. Thank you for that question. We agree completely. The system was in no way at all ready for a crisis like this. This experience has certainly led us to rethink all of how we provide these services for individuals, as well as supporting families.

Treatment must be evidence-based. That is why access to medication-assisted treatment is so critically important, and we see at times where families really want their loved ones to try treatments that are not evidence-based, so there is education for everyone. Taking the stigma away from MAT is really important.

But then also that person-centered approach, as you mentioned, really is so important because everybody's journey is so different. One person may really want to do outpatient treatment, which works very well, so they can continue their job. Other individuals may really need residential——

Mr. DESAULNIER. Doctor, if I could stop you there. But as a family member, the challenge is we rely on the professionals to say that. I have had family members go into residential treatment and be outpatient. I expect the experts to make the assessment based on evidence-based research, and I want to support them. But my personal experience, like our witnesses today, from very divergent backgrounds, they have all had the same problem. The point of entry does not support you.

I just want to switch because I have very little time.

Ms. McNeil, we have to change the process. So, how could you look at not just performance standards for outcomes, which, Director Carroll, I appreciate you making a very real effort, but how can we look at what we did for cancer, for instance, to have the professionals do the work, but then what we missed in cancer is exactly what the families are having a problem with.

And last, it would be wonderful if GAO looked at our policies in the Federal Government and the state government that have reinforced the stigma and have put up obstacles, so that we do not just spend money on it and give it to someone else. This committee should look and evaluate the policies we have enacted that reinforced the system we currently have, whether it is HIPAA or anything else.

Ms. McNeil?

Ms. HILL. The gentleman's time has expired.

You can answer, briefly.

Mr. DESAULNIER. Thank you, Madam Chair.

Ms. MCNEIL. GAO would agree that evidence-based policymaking and decisionmaking is key. So, in the work that we have that we will be starting up soon, I think that is one of the things that we will consider - looking at programs that have worked well and bringing that to bear and making sure that that information is provided to you all.

Ms. HILL. Thank you.

I recognize Mr. Hice for five minutes.

Director CARROLL. Madam Chairwoman, I know I do not get to reclaim 30 seconds, but for the sake of parents and family members out there, may I just make sure that they are aware of a website where they can go for treatment?

Ms. HILL. Yes, please.

Director CARROLL. Thank you.

In working with HHS, ONDCP did put out a website for parents to go and find a locator, so thank you for that. For any parents or individuals who have an addiction, they can go to *www.samhsa.gov/findtreatment*, so they can find centers.

Thank you. I apologize.

Ms. HILL. Thank you.

Mr. Hice?

Mr. HICE. Thank you, Madam Chair.

I would ask unanimous consent to have submitted into the record a CNN article about how the Trump Administration won a major policy shift from the Chinese on fentanyl.

Ms. HILL. So, ordered.

Mr. HICE. Thank you very much, Madam Chair.

Director Carroll, from what I am hearing, is it accurate to say that you are continuing to track the increases of fentanyl coming across the southern border? Is that correct?

Director CARROLL. Yes, sir. We have to.

Mr. HICE. And you described it as frightening.

Director CARROLL. Yes, sir. Scary for the parents and the kids out there.

Mr. HICE. Absolutely, for our entire Nation.

Now, the flow that is coming across the southern border is not by any stretch limited to our ports of entry; correct?

Director CARROLL. Absolutely not, not at all.

Mr. HICE. Okay. So, there is no question while we are seizing a significant number of illegal drugs at our ports of entry; correct?

Director CARROLL. Yes. We are seizing it all along the border.

Mr. HICE. All right. But a lot of it at the ports of entry, I would assume, primarily, because we have the resources there, the manpower, the dogs, those types of resources and others?

Director CARROLL. We are able to concentrate law enforcement at those areas, at the POEs.

Mr. HICE. That is right, and just because we have those types of resources there, it is safe to assume that we have tons of illegal drugs coming in-between our ports of entry.

Director CARROLL. Absolutely. I think it is key to note that seizures do not indicate flow, and we know from the flow that we are able to capture between the ports of entry that that is a fraction of what is coming across.

Mr. HICE. That is right, and that is because we do not have the resources in-between the ports of entry, or the manpower; correct?

Director CARROLL. That is correct.

Mr. HICE. All right. So, besides your conversation with Mr. Roy a while ago talking about the importance of addressing the cartel issue between the ports of entry primarily, would you also agree that securing the border, the entire southern border, would stem the flow of illegal narcotics?

Director CARROLL. We have to secure the country, and that starts with securing the southwest border.

Mr. HICE. Now, you mentioned also that fentanyl is coming largely into this country from China, that they are a major producer, I think 160,000 chemical companies in China, and they are going to Mexico or whatever, and then across our southern border. How important is the article? I do not know if you saw the article that I just had submitted, but China now referring to fentanyl as a controlled substance, how significant is that?

Director CARROLL. What we have to do is make sure that China understands that they are about to become the drug dealer of the world, and we have to make sure that they are aggressively enforcing the class scheduling that became effective May 1. Both on the intel side in the classified setting, as well as in the public space, we are going to be able to track what China is doing to actually live up to their agreement. We have to.

Mr. HICE. And what kind of impact will that have?

Director CARROLL. I think it is going to have a significant impact. Congressman Roy held up the map or the graph that showed the amount of fentanyl. While we are here today talking about American lives, this is really a global problem. If you were to see the graph for Canada, which was just put out publicly this week, it is almost the exact same. I mean, this is becoming a worldwide problem. We have to take care of Americans, but China has got to stop.

Mr. HICE. I could not agree with you more.

Sheriff Ivey, let me go to you with this same question. What kind of impact do you think the Chinese now referring to fentanyl as a controlled substance, what kind of impact will that have on you?

Sheriff IVEY. I would go back to what you were saying earlier about the ability to deploy resources in other capacities. Right now, fighting this opioid epidemic is draining my resources. My team, for example, just in one case was committed for six months to this lengthy investigation. So, being able to stop it at the border, being able to stop incoming into our country would give me the ability

to shift my resources to do the other crime prevention efforts that we need to be focused on.

Mr. HICE. Well, I hope we are succeeding, going to succeed in doing that.

Director, coming back to you, probably for my final question, you say we have got to enforce this with China. What type of things do we need to keep our eye on as it relates to China, whether they are serious on this?

Director CARROLL. There are two things that I think we can see right off the bat in the public space. One is having them talk about it publicly, having the government officials there do what you all are doing and having hearings on this, talking about this. The other thing that we will see in the public space is actually prosecution and enforcement of drug traffickers, of those who are producing fentanyl. If we see those two things in the public space, we will be able to get a sense that China is taking this seriously.

Mr. HICE. Thank you.

Ms. HILL. The gentleman's time has expired.

Mr. Khanna, I recognize you for five minutes.

Mr. KHANNA. Thank you, Madam Chair.

Thank you to the witnesses.

Thank you, Director Carroll, for your service. As you know, buprenorphine has been crucial to the treatment of disease for opioid addiction. Currently, about six percent of doctors have the authorization to do that. I appreciate that you have called for increasing that goal to 10 percent in five years.

I guess my question is, when you look at France's experience when they had a major epidemic in the 1980's and early 1990's, they eliminated completely the similar waiver requirement, and my understanding is opioid overdoses dropped by nearly 80 percent after they did that. Why have a goal of only 10 percent? Why can we not be more aggressive in that?

Director CARROLL. Buprenorphine is a very effective medication for those suffering, but it is not without its own dangers. So, we do need to make certain that the people who are prescribing it are properly trained. The original cap for doctors was to make sure that they are able to focus in on the patients instead of just writing prescriptions, are not out of control.

The original cap was 100. The Secretary of HHS engaged in rulemaking and moved that up to 275. So, we are seeing how that is going. But I think you are right, and that is one of the goals, to make sure that buprenorphine is more available to individuals who are suffering from the disease of addiction.

Mr. KHANNA. Would you be open to studying what France did and looking at how they managed to get rid of the waiver and seeing if there is something we can learn there?

Director CARROLL. We are working with HHS, and it is actually one of the things that they are doing now, is to make sure that everyone understands the impact and to see if—just like what we were doing with Huntington, the lessons learned.

Mr. KHANNA. Are you supportive if this Congress allocated $100 billion over 10 years to help you and others fight this opioid epidemic?

Director CARROLL. I am certainly supportive of any effective, efficient means of taxpayer dollars to save lives. In terms of the right amount, it is hard to say what the right amount is, at least in the next two minutes and 45 seconds. But certainly in the CARE Act the heart is there in terms of what we need to do to prevent this, treat this, and stop the flow from coming in.

Mr. KHANNA. And that is, of course, our Chairman's bill, Chairman Cummings. Do you think that could be an area of potential bipartisan cooperation, that we get something like that passed?

Director CARROLL. I probably should not say this publicly, but I actually enjoy a good relationship with Chairman Cummings. Please do not report that back. I hope the mic is off.

On this issue, it really is bipartisan, and I have good conversations with Chairman Cummings, his counsel, on the minority and majority side, to try to figure out how we are going to do this and save lives.

At the end of the day, that is all I think any of us care about, if we are going to save lives, how we are going to do it, how we are going to spend taxpayer dollars wisely. These are tough questions, though.

Mr. KHANNA. Dr. Rattay, I wanted to ask you about the Vermont model, the hub and spoke system where we have seen terrific success, where people are not just treated for their mental health issue and drug addiction but also given counseling, given a way to reintegrate with society.

What is your view of that hub and spoke model and whether it could be replicated in other parts of the country?

Dr. RATTAY. We really have learned a lot from the hub and spoke model. One of the ways in which it showed in Vermont to be helpful is by having primary care providers providing treatment, learning how to help manage individuals. You could increase treatment capacity significantly. In Delaware we have created a similar model that we call the START system. But really, again, what is so important is that you engage people in treatment, that it is effective evidence-based treatment, which includes both the physical, the mental health, and the wrap-around services that people need, and that it is really treated as a disease, which is why primary care providers and buprenorphine play an important role in considering it just a disease like any other.

Mr. KHANNA. I am glad you are making progress in Delaware. My understanding is in Vermont—and I am not sure of the statistics in Delaware—opioid injections have actually fallen almost 90 percent. How much do you think that we can look to the expansion of Medicaid that helped the Vermont program, and how important do you think expanding Medicaid is to being able to deal with the opioid addiction?

Dr. RATTAY. It is so important that individuals have access to treatment, effective evidence-based treatment. In our state, expanding Medicaid has been very helpful to increase access to treatment for individuals in that expansion group, but it has also enabled us to free up funding to be able to increase our overall treatment capacity, as well as increase some of those wrap-around and other services that are important, including peer recovery coaches or working on addressing housing or other issues.

Mr. KHANNA. Thank you.

Ms. HILL. The gentleman's time has expired.

I now recognize Mr. Cloud for five minutes.

Mr. CLOUD. Thank you.

Let me again first echo the sentiment of so many others on this committee to the families who came here and shared their personal stories. It was truly touching. And to the members here, and Dr. Carroll specifically, how you keep bringing back the focus on saving lives, I think that is keeping this committee in the right spirit, that that is really what we are trying to do here, is to save lives.

Of course, Sheriff Ivey, I appreciated your analogy about the bulletproof vest and that this is a multi-layered approach. We talk about prevention, we talk about treatment, and both are needed. I was happy to hear that, from a financial standpoint, we are investing in both of those substantially and need to continue to do so.

I happen to be from south Texas, and my community is right in the middle of what is called the fatal funnel, where two highways converge from the southern border, and then drugs and, unfortunately, human trafficking is dispersed throughout the Nation and beyond through that. As my friend from Texas was talking about meth coming across the border, the majority across the southern border, we have the issue with fentanyl coming between the borders.

It is really a mess down there. I have been down to the border, talked to Customs and Border Patrol, and I asked them, I said what is the next win for you, and they said we would like situational awareness. We want the tools and resources just to have situational awareness. We are not at the point yet where we are trying to mitigate the problem. We are just trying to understand what is going on. I think that is a travesty.

A couple of weeks ago I was back in the district and had the opportunity to sit in on what is a weekly law enforcement briefing where the law enforcement, Highway Patrol, sheriffs, police officers from throughout the district that I live in meet weekly to talk about how what is going on at the border is affecting what they are dealing with throughout the region, and it is certainly with the hospitals that are having to deal with this, the schools that are having to deal with this, it is certainly having an impact, and there is the lives and friends and family that we all have that have people who have dealt with addiction and the consequences of it.

My question is what tools do we need? What are we doing to disrupt the drug trade, and what tools do we need to mitigate this crisis? Because treatment is awesome, and we want treatment. What is even better is if people do not need it.

Dr. Carroll, I guess you can start.

Director CARROLL. I realize you could talk to any of us and we probably all—actually, we probably do not have dissimilar ideas.

One thing is we need to start at the very beginning, as I talked about earlier, with the prevention programs that are out there that are targeting kids to make sure that they understand. Our drug-free communities, we have 731 plus 55, and I appreciate the 55 because of Congress. We have 786 Drug-Free Communities across the country. What we are seeing there is a rapid decline in past–30-

day drug use of kids, and we talked about kids earlier today, and so that is critical.

The treatment admissions are up. We need more. There is no question that we need more people accessing treatment, and we have to make sure that they can find it. That is why the HHS Treatment Locator is so important.

But then we also need the third pillar, which is the law enforcement and interdiction side of this. We have all of our partner agencies working together at the national, state, local, and tribal levels to make sure we do this. So, it is with our partners at DEA. I am proud to have my HIDTA, my High-Intensity Drug Trafficking Area, pin on today. We love our HIDTAs because they are a combination of law enforcement working together, as you heard Sheriff Ivey say, and they actually work at these drug-free communities to make sure the prevention folks and efforts there work.

One last thing when we talk about what we can do, I would ask that the members of the committee go back to their jurisdictions. One of the things that the HIDTAs have developed is an OD map system. There are many places in Delaware that use it, and we are trying to get more states. Chairman Cummings was instrumental in getting an awareness to Maryland so every county in Maryland now provides real-time data not only to law enforcement about where overdoses are occurring so that they know they have a problem, but more importantly it provides it to the public health officials in the community to get ready, there is a spike, there is something happening in this area of town. It is all anonymized so there is no privacy information concerns, but it allows public health officials to be aware, schools to be aware, and even in some counties parents who have a child who is suffering from an addiction. Sometimes they will get the alert so they will know, oh-oh, I am not going to let my kid out of the house tonight.

Ms. HILL. The gentleman's time has expired.

Mr. CLOUD. Thank you.

Ms. HILL. I recognize Mr. Welch for five minutes.

Mr. WELCH. Thank you. Thank you very much.

Dr. Rattay, I want to just ask you a little bit about the wrap-around services. I am from Vermont, and we heard some questions from my Silicon Valley friend about Vermont, but I want to ask you about Delaware and wrap-around services. How essential are they, and how can we provide them?

Dr. RATTAY. They are very essential.

Mr. WELCH. Define it, define what that means.

Dr. RATTAY. So, when we think about wrap-around services—well, they are defined differently by different folks. I mean, when we talk about comprehensive services, we want to make sure that individuals do not just have their opioid use disorder treated but also any other mental health conditions, as well as physical health conditions.

But then also, for a person to be able to be successful in recovery, they need to have a safe place to live, and they are going to do much better in recovery if they are either on a pathway toward a career or they have a job, or both. Whether it is legal issues that are making it difficult for them to stay in recovery because they are

very anxious, we have to make sure that we understand what is it that a person needs to be able to stay in recovery.

We also include peer coaches, peer recovery coaches as a part of that as well, because they are very important for people to navigate.

Mr. WELCH. Can you talk a little bit about that? Because it is so hard, if a person gets addicted, it is such a challenge for that individual to try to stay the course, especially when, by the time they get to that point, a lot of the supports in their life have vanished, including people in their lives. Can you just comment on the challenge that is there for service providers?

Dr. RATTAY. Yes. I mean, first of all, it is a difficult system to navigate. There are so many different parts to the system, so just navigating the system itself, most people, families and individuals, really need help navigating the system. But because there is so much stigma as well, they need somebody they can trust who is not judging them to help support them in their journey for treatment and recovery. This is why we found peer recovery coaches to be so helpful for individuals, getting them connected to treatment and navigating.

Mr. WELCH. Thanks.

Let me ask Director Carroll about the peer support. Somehow that makes an awful lot of sense to me. In our roundtables in Vermont, the peer coaches just had an immense amount of credibility with folks who are struggling with an addiction.

Director CARROLL. They really do. They are really able to reach out to people that are struggling and say I have been there, I will hold your hand, I will help get you through this.

Again, talking about the Democratic mayor in West Virginia who I am friends with because of this—sadly, it is because of this. But to go back to the communities, one thing that they have developed is the QRT, quick response team, and other communities have it as well. But people who have just had an overdose and thankfully their life has been saved because of naloxone, something that most people should carry—I had all my staff trained on it. The next day, after someone has survived an overdose, four people go see them because they know at that point they are most receptive. It is a member of law enforcement who is not wearing a uniform at the time but to say, look, I will take any drugs you have, I am not going to arrest you. It is a member of the public health team. It is a member of the faith-based community to say I will provide support if you have family or children. But it is also someone in recovery, a peer. So, when you go back home and think about this type of QRT, quick response team, it works.

Mr. WELCH. Thank you very much.

Sheriff, what do you think about peer support, and what frustrations do you and your officers face when you are called to a scene involving a person that you were called to a week or two weeks before?

Sheriff IVEY. It is incredibly frustrating and, quite frankly, heartbreaking, especially when you see the potential end result, like we heard from many of our parents and family members today. From the peer support aspect, I cannot speak enough about that because, as Director Carroll said, having somebody who has been through

it that can help guide you through it, we use that same aspect or concept, if you will, in helping officers who have been involved in shootings or other critical incidents. So, the peer support group is going to be of great value.

But to speak directly to frustrations, we spend an incredible amount of time doing just that, responding over and over again to those who are addicted to this.

Mr. WELCH. I yield back. Thank you.

Ms. HILL. Thank you.

I would like to recognize Mr. Grothman for five minutes.

Mr. GROTHMAN. Yes, thanks for being back here again.

I do not remember if I asked this question last time. A relatively high percentage of American troops used heroin in Vietnam, and within a few years of returning a very small percentage of those people were using heroin. What happened there?

Director CARROLL. I am sorry, I am happy to do some more research into the Vietnam era and get back to your staff. One thing I am sure about is there was not fentanyl coming over from China and coming up from Mexico.

Mr. GROTHMAN. That is true. I am just saying—who knows what to believe on the Internet, but from what I read, about 15 percent of American troops in Vietnam were using heroin, maybe even described as heroin addicts, and they returned, and in a relatively short period of time that number almost entirely disappeared. I wondered whether any of you four experts were familiar with that or have looked into it.

Director CARROLL. I am not familiar. I am happy to look into it and get back to you.

Mr. GROTHMAN. Good.

Yes, Sheriff Ivey?

Sheriff IVEY. Yes, sir. The only thing I can speak to is, in talking with my team, we are seeing an increasing number of our veterans that are falling into this epidemic, and that is both accidental and intentional overdoses that are taking place, and that is one of the things that we are looking at.

Mr. GROTHMAN. Okay, that is okay.

The next question that just popped into my head. As far as when you are keeping track of these statistics, percent of people who die of a heroin overdose, do you know what percentage are married compared to the general population?

Director CARROLL. We do not track that. I can ask the CDC if they have such information and get back to you.

Mr. GROTHMAN. You should track that.

Director CARROLL. Sadly, I think what is happening is that it is more and more kids, younger people who are passing away, but I am happy to go back and see if——

Mr. GROTHMAN. Yes, see if the number of people who are age 35 die, what percent are married compared to the population as a whole.

Okay. Of all the programs you are familiar with, and I think everybody here who has any sort of political career has voted for all sorts of money to fight this, what is the most successful program? I mean, what program has, say, the highest rate of no relapse within five years? What is the best program you found?

Director CARROLL. We really have to be able to look at this as everything. We cannot—respectfully, I cannot take just one program. We have to do programs that work on prevention, and then on the treatment side we know that MAT is incredibly effective. We also know faith-based. It really is such an individualized one, it is hard for me to say——

Mr. GROTHMAN. Well, I will put it this way. Before you guys came up here, we heard some heart-rending stories of parents and a daughter whose mother or children died, and some of them just seem to go through this revolving door of treatment, treatment, treatment. And I just wondered, is there any program out there that you can say, at least say 70 percent of the people who go through this program do not relapse within five years? Is there such a program that exists?

Director CARROLL. I will say that probably the most effective thing that we can do that has almost zero dollars attached to it is getting rid of stigma, is telling people that it is okay to——

Mr. GROTHMAN. Is there any program like that? Does anybody know? For all the time we spend on this, can anybody say if you go to such and such a program in Columbus, Ohio, 70 percent of the people do not relapse within five years? Is there any such program that even exists?

Director CARROLL. This issue is so complex that there is not one single solution for individuals. We have to take this as a step-by-step process.

Mr. GROTHMAN. Well, I know we do, but we have been studying this thing forever. I mean, I have done this job for three or four years. I wish I could keep track of all the hearings I have spent before this. Do we know of any program that we can say that, say, I am going to send my son here, whatever, and say with 70 percent certainty that person will not relapse within five years? Is there any such program?

Dr. RATTAY. There is no magic program like that at this point. But we——

Mr. GROTHMAN. How about 40 percent?

Dr. RATTAY. But we have learned a lot over——

Mr. GROTHMAN. I only have five minutes. Is there a program that you can even say 40 percent of the people have not relapsed within five years?

Dr. RATTAY. Again, I agree with the comprehensive approach. If I were to point to one thing, medication-assisted treatment——

Mr. GROTHMAN. So, there is no program, or you just do not know.

Dr. RATTAY [continuing]. Is critical.

Mr. GROTHMAN. Final question. As far as other countries—and maybe I will give this to Sheriff Ivey. Some people do not like to deal with deterrence, you know, let's do treatment but we cannot deal with deterrence. I went to Taiwan about 14 years ago, and they have almost no drug problem. Can you tell us what type of—does deterrence work in some of these southeastern Asian countries?

Sheriff IVEY. I am assuming by "deterrence" you mean the type of penalties and the incarceration——

Mr. GROTHMAN. Yes.

Sheriff IVEY. I am a strong believer—in fact, I absolutely advocate the harsher the penalty to these that are dealing—preying on those addicted, the harsher penalties we can give, hitting them with racketeering, conspiracy to racketeer, putting them away for life, is certainly a deterrent. I absolutely believe it.

Mr. GROTHMAN. Yes, these——

Ms. HILL. The gentleman's time has expired.

I recognize Ms. Pressley for five minutes.

Ms. PRESSLEY. Thank you, Madam Vice Chair.

Structural racism and systemic biases have shaped our responses to addiction, which has resulted in the criminalizing and the devastating of whole communities for decades. I do believe we perpetuate those practices when we ignore and leave out of the conversation and the profile of who has been impacted by this public health crisis and epidemic expectant mothers, when we leave out the black and Latinx communities, and when we leave out those that are incarcerated.

Again, one of the groups most at risk of opioid-related deaths—and pregnant women and new moms have been especially vulnerable. The CDC found that the number of pregnant women with an opioid addiction more than quadrupled in the last 15 years. And for these new moms experiencing addiction, a year after childbirth is the deadliest.

Mr. Carroll, what is ONDCP doing to partner with HHS to improve comprehensive health services, particularly for postpartum women, who are often most susceptible to relapse and opioid-related overdoses?

Director CARROLL. One of the things that is important to do is to make sure we are reaching every community that is out there. You mentioned the incarcerated. Let me start with the order that you went. You were talking about the population that is incarcerated, and it——

Ms. PRESSLEY. We can go there, but I would like to stay on the moms right now.

Director CARROLL. I am trying to answer your question.

Ms. PRESSLEY. Okay.

Director CARROLL. And I will get there, I promise.

What we are trying to do for the incarcerated population, sadly, in many communities, those are the facilities that provide the most treatment for individuals. So, that leads to change, but the change is at the fundamental level in making sure that we are not criminalizing addiction and so fewer and fewer people are going to jail. We are doing that—we did an additional $4 million in drug court diversion so they are not going to jail and they can get treatment on the outside.

In terms of——

Ms. PRESSLEY. I am sorry. So, yes or no, does that mean that ONDCP is working with the Bureau of Prisons to expand access to medication-assisted treatment for incarcerated people? Since we know that two-thirds of incarcerated people suffer from substance abuse disorders, and only one-quarter of those people receive any drug treatment.

Director CARROLL. One of the things that is important when we talk about——

Ms. PRESSLEY. Yes or no, do you have a partnership? I am sorry, I have a limited time. I am trying to be respectful.

Director CARROLL. And I am trying to be respectful, too.

Ms. PRESSLEY. Okay.

Director CARROLL. What we are trying to do is expand the number of prescribers, because once we have a bigger work force, we can get more people into an incarcerated population to provide them the treatment that they need.

Ms. PRESSLEY. So, those reentering society, they are 40 times more likely to die from an opioid overdose.

Director CARROLL. And there are some local jails that are doing this. We are trying to incorporate it at the Federal level as well.

Ms. PRESSLEY. Okay, very good. Thank you.

Director CARROLL. But one thing it is important——

Ms. PRESSLEY. I am short on time. I want to get to my question about moms.

Director CARROLL. In terms of moms, that is one of the saddest things that you see is when you see a child who has NAS and they truly have that pain. So, the idea is making sure that we are having specialized care for them with HHS, to make sure, such as Lilly's Place in West Virginia that we talked about, and other places, to make sure we are going right at—we have to treat these——

Ms. PRESSLEY. Excuse me. I am sorry. But at the same time, you are intent on overturning the ACA, rolling back protections for preexisting conditions, and undermining the expansion of Medicaid, which can be a critical source for addiction treatment. So, yes or no, will this Administration's attack on the ACA and efforts to stop Medicaid expansion help tackle the opioid epidemic?

Director CARROLL. The failed policies of health insurance do not actually mean health care, and I think it is important that we understand that at the outset. We have to make sure, and it is my responsibility to advise the President on making sure that as the reforms go forward, getting treatment to individuals is the most important thing that I can do in terms of helping whether it is moms who have an addiction, parents, children, or anyone. That is my responsibility, to make sure that we have a health care system that works.

Ms. PRESSLEY. Excuse me. I just want to be clear, because mothers are dying. Do you believe the Administration's efforts to undermine the ACA will help in the opioid crisis?

Director CARROLL. I believe that the health care policy going forward will save more lives, absolutely. We are going to make it a sound policy.

Ms. PRESSLEY. Okay. We disagree on that.

In my home state of Massachusetts, the opioid crisis is robbing lives at a rate that is two times higher than the national average, and the death rates in black and brown communities are spiking at record rates. Yet these communities most at risk are less likely to have access to critical services and medication-assisted treatment.

Mr. Carroll, what is ONDCP doing to ensure that black and Latino communities are not left behind?

Director CARROLL. One of the things we have to do, as I talked about a minute ago, was to make sure that there is not stigma in terms of the population, the prescribing population, to make sure that we are getting treatment and facilities that provide quality, effective care. Sometimes we have seen in communities, especially in urban areas, our methadone clinics that are not providing quality care. What we have to do is make sure that there are qualified individuals out there providing MAT——

Ms. PRESSLEY. And also culturally competent. I just wanted to add that.

And then just for the balance of my time, we do not have much time for you to answer but I just want to say on the record, your Administration has indicated that they plan to eradicate and end the HIV and AIDS epidemic in the next decade. So, I do hope that this is a part of that broader strategy since we do know a number of the new infections. There is an overlay in all of these issues.

Director CARROLL. God bless you. I hope you are right.

Ms. PRESSLEY. Okay. I yield my time.

Ms. HILL. Thank you so much.

I now recognize the Ranking Member for five minutes.

Mr. JORDAN. Director Carroll, what year was the ACA passed?

Director CARROLL. Boy, you are probably a better guess. Four years ago? Five years ago?

Mr. JORDAN. It passed in 2010.

Director CARROLL. Okay. Time flies. Sorry.

Mr. JORDAN. Is it still the law?

Director CARROLL. It is.

Mr. JORDAN. Yes. And what has happened to the opioid crisis during that time?

Director CARROLL. We have seen the number of deaths just skyrocket.

Mr. JORDAN. Yes. So, the idea that somehow the Trump Administration and us trying to do what we promised the voters we were going to do, which is replace, repeal and replace the ACA, that has not happened. So, the idea that that somehow has contributed to this terrible crisis across the country is just crazy; right?

Director CARROLL. We need an efficient and effective system to get help to people.

Mr. JORDAN. I agree.

Sheriff, how big is your county?

Sheriff IVEY. A population of 600,000.

Mr. JORDAN. Big county.

Sheriff IVEY. Yes, sir.

Mr. JORDAN. How long have you been in law enforcement?

Sheriff IVEY. I have been in law enforcement almost 40 years, sir.

Mr. JORDAN. Forty years? Most of it in your county?

Sheriff IVEY. No, sir. Actually, I served—the biggest part of my career is supervisor with the Florida Department of Law Enforcement across the state.

Mr. JORDAN. Across the state. A pretty big state, too.

Sheriff IVEY. Yes, sir.

Mr. JORDAN. Yes. So, in 40 years of experience in a county of 600,000 that you are now the sheriff of, and then I think in my

opening remarks I talked about you had a fentanyl bust of like—I forget how many pounds. What was the number?

Sheriff IVEY. The investigation yielded three pounds of fentanyl.

Mr. JORDAN. Which is enough, as I think I said, or someone said, enough to kill——

Sheriff IVEY. In lethal dose form, it would have killed everybody in my county.

Mr. JORDAN. Yes. That is serious. Do you know where that came from?

Sheriff IVEY. We know that the direct point to us was from Georgia. That is where the subject picked it up. But according to our partners with DEA, we see the fentanyl coming in from China and through Mexico.

Mr. JORDAN. Yes, like Director Carroll has talked about and most of us know.

And I think earlier you talked about what we need to do on the border. Would you describe the situation on our southern border as a crisis?

Sheriff IVEY. There is absolutely no question. We need to secure our southern border. In doing so, we will eliminate and eradicate a lot of problems that law enforcement faces each and every day.

Mr. JORDAN. And potentially, when you go after the supply, you can potentially help stop some of the tragic stories we heard earlier this morning from the families who have lost a loved one.

Sheriff IVEY. Yes, sir, absolutely. In fact, one of our families this morning talked about law enforcement did not go after the dealer. I am a strong, strong advocate of we need to go after these dealers with every ounce of passion we have to lock them up. They are preying on the addictions of others.

Mr. JORDAN. Question that is related, not maybe directly to this, but what is your position on liberalizing marijuana laws?

Sheriff IVEY. I am absolutely 1,000 percent against it.

Mr. JORDAN. In your experience, 40-some years in law enforcement, sheriff of a county of over 600,000 people, do you think liberalized marijuana laws can lead to, then, this addiction problem in the opioid area?

Sheriff IVEY. Yes, sir. Actually, the greatest education I ever got in why we should not legalize marijuana came from our chain gang who we use often to talk to parents who are trying to help their kids stay out of trouble. They absolutely said that marijuana, the dealers of marijuana turned them on to the other dealers who then sold them coke and heroin and the other things. So, ironically, out of the mouths of what you would probably call criminal experts because they are sitting in our jail, they say it is a bad move as well.

Mr. JORDAN. Yes. Mr. Sheriff, we appreciate your service, and all of you, for your testimony today.

Director Carroll, what are your thoughts on liberalizing marijuana?

Director CARROLL. What we have seen is that the marijuana we have today is nothing like what it was when I was a kid, when I was in high school. Back then, the THC, the ingredient in marijuana that makes you high, was in the teens in terms of the percentage. Now what we are seeing is twice that, three times that in the plant. But then in the edibles, 80 percent, 90 percent THC. We

just do not understand yet. We are doing more research. DEA is working hard. HHS is working hard to make sure that we understand the impact of legalization of marijuana on the body. We know already the impact it has on——

Mr. JORDAN. One of the things that passed out of the Judiciary Committee last Congress was this idea that—and I think this is where you were going, Director—we need the research and the studies done before we allow this to happen, we liberalize these laws, as some states have already done. It seems to me at least figure out what the research shows, and I see Dr. Rattay shaking her head as well. Would you agree with that?

Dr. RATTAY. Yes, I would.

Mr. JORDAN. All right. I appreciate that. Thank you all.

And with that, Chairman, I yield back.

Ms. HILL. Thank you.

I recognize Congresswoman Speier for five minutes.

Ms. SPEIER. Thank you, Madam Chair.

And thank you all for the good work that you are doing.

Director Carroll, when you last were with us, I submitted a question for the record, asking you to provide the status of each of the 56 recommendations from the Christie Commission, including whether ONDCP or other Federal agencies had adopted the recommendations, the reason why the recommendation was or was not adopted, and all actions taken or planned to be taken by ONDCP or a Federal agency in furtherance of the recommendation. So, it is important once we create these commissions, they come up with these far-reaching recommendations, that we actually act upon them.

So, your response to me was a one-pager, as well as a one-year report update on the Commission. Neither of these documents provides specific information I requested on each of the 56 Commission recommendations.

So, I am going to ask you one more time. Can we as a committee receive from you a complete response to each of the 56 recommendations whether or not you have taken action, and if not, why not, so that we can have a full understanding of whether or not you have implemented those recommendations?

Director CARROLL. We have given you a full answer in terms of how the Commission—we grouped it into headings of nine, because that is the way, when you look at the report, how they fell. In terms of if there is a specific question, I am happy to work with your staff to explain as to specific questions.

Ms. SPEIER. All right. Maybe—you know what? All we are doing is asking for information that you should be able to provide us.

Director CARROLL. I am able to—ma'am, I just said I will provide it.

Ms. SPEIER. Okay. Then that is what we will do.

Director CARROLL. I am happy to come up and talk to you about it.

Ms. SPEIER. Then that is what we will do. We will have you come up, and you can make a presentation to me and anyone else on this committee who would like to go over recommendation after recommendation, and we will go over all 56, if that is easier for you to do.

Director CARROLL. Ma'am, I am trying to save lives on a daily basis.

Ms. SPEIER. I understand that. So, are we.

Director CARROLL. And so what I am trying to do is make sure that I am focusing on the priority targets. I gave you a response to the Commission and, as I said, I am happy to go—if you have a specific one you want to go through, I am happy to send my staff up to work with your staff or to work with you.

Ms. SPEIER. That is not what you just said. You said that you would come up.

Director CARROLL. I said I would—I am happy to come up with my staff and sit down and answer any questions about a specific one you want.

Ms. SPEIER. All right. Then I will get specific questions, and they will be submitted to you, and then you will come up with your staff, and we will invite other members of the committee to join me to get the——

Director CARROLL. I want to be sure I send the right staff to answer your questions, ma'am.

Ms. SPEIER. I think you are being very belligerent, and I do not think that is conducive to us working together.

Director CARROLL. I think I am trying to answer this in the most bipartisan fashion I can. And in terms of being belligerent, I am trying to get you answers that you want.

Ms. SPEIER. All we did was ask you to respond to the fact that Mr. Christie was in charge of this Commission, he came up with 56 recommendations. We wanted to know where you were in implementing the 56 recommendations, and instead you sent us a one-page with another document that does not really answer whether or not these 56 recommendations have been implemented. It was a pretty simple request, and it should have been something that you could have responded to in a very simple manner, but you chose not to.

Director CARROLL. I think I did respond in a very simple manner that pretty much anyone can read and see exactly how we went about trying to answer these questions.

Ms. SPEIER. Well, that was not sufficient, so you can come back, then. Thank you.

Director CARROLL. I will send the right staff to come back and meet with you, ma'am. Do not worry.

Ms. SPEIER. Again, I object to the tone that you are using——

Director CARROLL. I object to the tone you are using.

Ms. SPEIER. Well, you do not have the right to object to my tone, because we have two different roles here.

Director CARROLL. Yes, ma'am. I am saving lives.

Ms. SPEIER. I have oversight role——

Director CARROLL. And my job is to save lives, and that is what I am trying to do every day.

Ms. SPEIER. Well, if you are trying to do that every day, I would think you would want to work with the committees that have the authority to provide you with the resources to do your job so you can save more lives.

Director CARROLL. I have a great relationship, I think, with most members of the committee and their staff. We are trying so hard.

We have been working with GAO. They have been a great partner in the last 60 days to be able to work with them and show them exactly the direction we are going.

Ms. SPEIER. Well, if I remember correctly, GAO was not happy with how the Office was operating and made recommendations. I am glad to know that Ms. McNeil feels that you are indeed responding to them.

Is that true, Ms. McNeil?

Ms. MCNEIL. Yes. We have had four meetings with ONDCP staff since the last hearing, and then we had an additional briefing where I brought some experts over and walked them through some best practices related to collaboration and strategic planning.

But I do want to highlight there are two things we have been asking for that we really need from ONDCP for us to continue to make progress. One, the budget guidance that they used before there was a Strategy. We need to understand what that guidance entails. And two, the National Security Council's Strategic Framework for Reducing the Availability of Illicit Drugs. The staff told us that is what they used in lieu of a Strategy in prior years. We would like access to that. We asked for it in December and still have not received it.

Ms. SPEIER. Okay. So, you asked for it in December and have not yet received it——

Director CARROLL. Ma'am, if you listen to what she just said——

Ms. HILL. The gentlewoman's time has expired.

Director CARROLL.—by the National Security Council. We do not own the document. I am not the National Security Council. We have given them the information——

Ms. HILL. Director Carroll, I need you to stop. Thank you.

Next I would recognize Mr. Comer for five minutes.

Mr. COMER. Thank you, Madam Chair, and Director Carroll, and Sheriff Ivey. I just want to thank you for doing everything you can to try to save lives, and I believe that you all are trying to save lives.

We have had committee hearings here and countless meetings and discussions about the opioid issue and crisis for months and years, and one of the things that has been mentioned today by the Sheriff and others is that we have a drug problem in America, and many of the drugs are coming illegally across the border. We have a President and at least a majority of one party that is serious about securing the border to try to stop the illegal flow of drugs into the United States, and I think that what we are seeing from a few members of this committee in differing parties is that one party wants more money, more money, more money, and at the end of the day, until we cutoff the flow of illegal drugs crossing the border, we can spend all the money in the world, we are still going to have a major drug problem in the United States.

So, I think it is important to reiterate the fact that if we are serious about stopping the flow of illegal drugs into the United States, we are going to have to get serious in this Congress about securing the border. So, I just wanted to mention that.

And in my remaining time, I kind of wanted to shift gears because I think that the biggest part of the opioid problem we have had in America is the business model to treat pain has been wrong.

Doctors, at least in my Kentucky district, have, for whatever reason, over-prescribed opioids for the treatment of pain, and I think that we have come a long way in education, in educating our medical providers on the perils of opioids.

But my question, Director Carroll, is as we move forward and we talk about the opioid issue, again, I will say over and over, I think the number-one thing that we can do is secure the border. But as we move forward, there are a lot of people in America that have legitimate pain, and there are people that deserve and have the right to treat their pain.

One of the things that I have been doing a lot of research on is alternative forms of pain treatment. In Kentucky, before I came to Congress, I was Commissioner of Agriculture, and we became the first state to legalize industrial hemp. The hemp industry in Kentucky and in many states now is really booming. It is an emerging industry. And one of the biggest products that is coming from industrial hemp is CBD oil, cannabinoid oil, non-THC, so we are not talking about marijuana, we are talking about hemp, non-THC CBD oil for treatment of minor pain like inflammation and other forms of minor pain. This seems to be really making a difference.

We also, in my research, my staff, we have listened to physical therapists, chiropractors, other alternative forms of pain treatment.

Director Carroll, what are your thoughts on how we move forward in trying to treat pain in America other than the old business model that has failed so miserably in prescribing severe pain medication?

Director CARROLL. One of the things that I think is important to do, and actually the Commission talked about this, was removing the pain questions when there are surveys for health care professionals. Working with HHS and working with Members of Congress, one of the things that we have done is removed the pain questions from the reimbursement side. So, effective October 1, 2019, the questions on pain as they determine reimbursement rates will no longer be asked.

So, the people understand that sometimes if you have—I think we were talking earlier, one of the young men who lost his life was because of an appendix, to be able to say to them it is going to hurt, you just had surgery. So, by removing the pain survey, that is one of the things that I appreciate [about] the committee and Chairman Cummings, and I have talked about too: making sure that we treat appropriate pain, but that we also do not spend too much of an emphasis on it.

In terms of the CBD, that is something again that I think HHS is going to regulate to make sure that we understand the health impact of it. I do not know if Dr. Rattay feels differently, but I think right now we are on the cutting edge of research to show the——

Ms. HILL. The gentleman's time has expired.

Director CARROLL. I am sorry.

Ms. HILL. I recognize Ms. Maloney for five minutes.

Mrs. MALONEY. I thank the Chairwoman for yielding and all of the panelists for your service.

One of the recommendations in the report really builds on the question of Mr. Comer, and I applaud his questioning. It is the

same that I have heard from doctors in the city that I represent, but they say they want to reduce opioid prescription fills by 33 percent within three years. I think one of the problems I have heard from doctors is the incentive is to give pain medication, and I am pleased that that question has been removed. It should be removed from everything.

Director CARROLL. Thank you for your help on that.

Mrs. MALONEY. They told me that they felt like they had to give pain pills because they were being drilled on it, and I think that removing it—my question is if you change the incentive and instead of asking people to rate whether the doctor took away all their pain, you could ask the question to the doctor: "Did you try every other alternative form of pain relief before you moved to an opioid?" Because what doctors are telling me is that there is Tylenol, all types of different pain relief that can help people. And I think if you changed that incentive, I think it would be better.

Personally, I think we should take opioids totally off the market unless you are in hospice, because it is harmful to people. From the stories that we read, most people are addicted by their doctors giving them these pills.

I want to tell a story of a constituent who became addicted in five days on opioids. She was in one of the finest hospitals in my district, and they asked her all the time to fill out forms on whether or not she was in pain. Of course she was in pain. She had a minor operation. They cut on you, you are in pain. She did not want all these pain pills. They kept giving them to her. When she left they gave her three different painkillers, big bottles of opioids to take home with her and fill out her form that she did not have any pain, because the doctors did not want to be rated badly.

So, I think removing that rating completely—it should not be anywhere—it should be removed, and I think the incentive should be changed to what are you doing to prevent having to go on opioids.

And my question is why do we continue to allow this to be legally dispensed when we know it is killing people? We know it is killing. The numbers are astronomical of people becoming addicted. This woman became addicted in five days.

Now, people are different. Some people will never become addicted for whatever reason, the chemistry in the body. She became addicted and had a difficult, difficult time getting off of it. But she did not want all these pain pills. They just kept giving them to her because the incentive was do you have any pain, you cannot have any pain, do not rate me for giving you pain.

But I would just like to ask the panel, what about changing the incentive and saying instead of do you have any pain, ask the doctor have you tried every other way to relieve the pain and give the incentive to the doctor to talk to the person that you may be uncomfortable for one day but you are much better off not taking these killer opioids.

If anybody wants to comment, I would like to hear your response.

Director CARROLL. I will just take 10 seconds at the end.

Dr. RATTAY. This is a tough-to-crack. Changing prescribing practices is much more stubborn than we realized. The Centers for Disease Control and Prevention has done a nice job reviewing the evi-

dence. I think we all know now opioids really are not very effective for pain management, and the risks are much, much higher. But access to alternative and more effective approaches to pain management has been limited.

So, one of the things we have done in our state is not only educating the public and providers but changing insurance——

Mrs. MALONEY. May I ask a question, with all respect? Why is it difficult? Why is it difficult for your states to have alternatives that could save a life if you kept them off of opioids? Why is it difficult? There is Tylenol. I mean, I am not a doctor, I do not know these terms, but there are lots of little drugs that can help you. Why is it difficult to get an alternative?

Dr. RATTAY. There is a lot of resistance overall. The public still has—there is a lot of demand for opioids for pain management. Physicians, many do not particularly want to be told to decrease their prescribing. But you mentioned, and I think it is very much the case, insurance is much better at reimbursing for pharmaceuticals, including opioids, and we are really pushing change to get chiropractic care, physical therapy. We have removed the caps for those in our state. We are now working on massage and acupuncture, requiring reimbursement for those, as examples.

But right now, a lot of people do not have access through their insurance to alternative approaches.

Ms. HILL. The gentlewoman's time has expired.

Mrs. MALONEY. Thank you.

Ms. HILL. With that, I recognize Ms. Ocasio-Cortez for five minutes.

Ms. OCASIO-CORTEZ. Thank you so much. I would like to thank the Chair and the committee for convening today's hearing, as well as all of our witnesses for joining us today.

While I am pleased to hear that the Administration is supporting efforts to combat the opioid crisis, and that the President's budget requests some discretionary funds for this purpose, it seems that upon closer inspection he is actually gutting the very programs that are critical to combating the opioid epidemic.

The Medicaid program is the Nation's single largest payer for behavioral health services, and it covers nearly four in 10 non-elderly adults struggling with opioid addiction, and adults with Medicaid are more likely than even the privately insured and the uninsured to receive substance use disorder treatment.

So, at the same time we should be dedicating greater resources to this critical program, the President's budget is proposing $1.5 trillion in cuts to the Medicaid program over the next 10 years, the very program that is the largest payer and the larger assistant in behavioral health services.

So, I have a question, Dr. Rattay. In your written testimony you speak about the importance of Delaware's Medicaid expansion. What would it mean for your state, and how would this impact your ability to respond to the opioid epidemic, if the ACA were repealed?

Dr. RATTAY. We have great concerns that if the ACA were repealed and we went backward regarding expansion, that many people would lose access to life-saving treatment services. So, on the flip side, Medicaid expansion not only has been able to enable us

to increase access to services for individuals, but it has also enabled us to use resources, other resources differently; so, for example, whether it is wrap-around services or peer recovery coaches.

Ms. OCASIO-CORTEZ. Have you seen any sort of relationship, whether it is correlative or otherwise, between states that have not expanded Medicaid and the depth of the opioid crisis there, and the ability of people to seek treatment?

Dr. RATTAY. I know that there has been a look at that, but I have not studied that closely.

Ms. OCASIO-CORTEZ. Thank you.

In addition to the opioid crisis, I think one of the issues that we have had here is that we do not see these crises hit until they are crises, especially on the legislative side as well. But we have to be able to identify emerging threats, and what I have been seeing here is one of the lessons that we learned from the opioid crisis and the rapid rise of fentanyl and synthetic opioids is that we need to be prepared to react quickly when new crises and new drugs emerge as threats.

Dr. Carroll, can you update us on the process of identifying emerging threats when it comes to drugs and public health? And when can we expect the Emerging Threats Committee to be up and running?

Director CARROLL. Thank you. If I may just spend 30 seconds responding to Congresswoman Maloney, Congresswoman Maloney referenced about reimbursement rates and tying it to pain. It is an interesting idea. Maybe we should take a reverse approach and for people——

Ms. OCASIO-CORTEZ. I would like to reclaim my time, Dr. Carroll. I am so sorry. Her time has expired.

Director CARROLL. I promise——

Ms. HILL. I will give you an extra 30 seconds.

Ms. OCASIO-CORTEZ. Great. Thank you.

Director CARROLL. Maybe that is a great idea to say when you cut down your prescriptions for—well, protecting chronic pain people, the reimbursement rates will go higher the fewer opioid prescriptions you write.

One of the things we are also doing is working with medical——

Ms. HILL. I want to be sensitive to time. Can you please answer the gentlewoman from New York?

Director CARROLL. Thank you. I apologize, Congresswoman, and I appreciate the committee, when you reauthorized us to make that a centerpiece. So, we have sent invitations out to 14 members across the country from every disciple, every discipline, and we will be hosting our first meeting with our new Emerging Threats Coordinator on time.

Ms. OCASIO-CORTEZ. All right. Great. Thank you very much.

Director CARROLL. I apologize for 30 seconds.

Ms. OCASIO-CORTEZ. No worries, no worries.

In fact, at our hearing in March, the Houston HIDTA Director McDaniels testified that, quote, "Our major threats in Houston are methamphetamine, cocaine, and synthetic drugs." Our country, unfortunately, has a history of racial inequity when it comes to how we pursue either enforcement or treatment, depending on the type of drug.

I was wondering if you agree that one of our goals should be to increase treatment for all drug addiction, including addiction to methamphetamines, cocaine, and other drugs in addition to opioids.

Director CARROLL. Absolutely. I think we need to—people say "opioid crisis" because that is what is killing so many people, but at its core, you are right, this is an addiction crisis, and we have to treat people as we find them.

Ms. OCASIO-CORTEZ. Thank you very much.

I will yield the rest of my time to the Chair.

Ms. HILL. Thank you.

With that, I will recognize myself for five minutes.

This question is to—well, first, I want to say thank you so much to everyone for testifying, especially to those who joined us earlier today.

But, Director Carroll, I am particularly glad to hear that you are testifying about the importance of evidence-based treatment. We actually see extensively in the GAO testimony that highlights that medication-assisted treatment is demonstrated that it reduces opioid use and increases treatment retention compared to abstinence-based treatment.

One of the challenges identified in increasing access to MAT is really about access to coverage, right? And the availability and limits of insurance coverage for MAT. You state that patients with no insurance coverage for MAT could face prohibitive out-of-pocket costs that could limit their access, and if coverage for MAT varied for those individuals with insurance and coverage varied. Insurance plans, including state Medicaid plans, did not always cover the medications, and they sometimes imposed limits on the length of treatment.

That said—I have a lot of papers here, by the way. Sorry. That said, we have the study that I earlier introduced from the American Journal of Public Health that stated that the ACA provides greater access to substance use disorder treatment through major coverage expansions, regulatory changes, requiring the coverage of substance use disorder treatment, and existing insurance plans and requirements for treatment to be offered on par with medical and surgery, as well as opportunities to integrate substance use and to mainstream health care. A Kaiser study, as mentioned previously, shows that 4 in 10 adults with opioid addiction are covered by Medicaid, and 21 million Americans have gained coverage through the ACA, including 12 million through Medicaid.

So, Ms. McNeil, do you believe that if the ACA is overturned, this issue of coverage would be better or worse?

Ms. MCNEIL. I will invite my colleague, Mary Denigan-Macauley, to answer that.

Ms. DENIGAN-MACAULEY. I apologize. Can you repeat the question, please?

Ms. HILL. The question was, given all of the information I just shared and your belief that access to coverage and provisions around coverage that makes it more difficult for people to get MAT, is this something that you believe would be made worse or better if the ACA was overturned?

Ms. DENIGAN-MACAULEY. Well, GAO would certainly encourage any increased access to treatment, and Medicaid is one program

that does improve access to treatment. So, our concern would be ensuring that that remains.

Ms. HILL. Do you have any estimates of how much was provided by Medicaid or how much was spent by Medicaid on such treatment?

Ms. DENIGAN-MACAULEY. We do not, but we do know that in those states that had Medicaid expansion, that there were more people who had the access, but we do not have a number.

Ms. HILL. Thank you.

And, Director Carroll, one of your goals listed in your Performance Reporting Supplement is increasing the percentage of specialty treatment facilities providing MAT for opioid use by 100 percent within five years. I recently visited one such facility in my district. It seems to be a great program, but they spoke extensively about the challenges around coverage, and the majority of their patients are covered by Medicaid, and others are covered by health insurance that in many cases they did not have prior to the ACA.

So, my question is, if the issue of coverage is exponentially exacerbated by a successful overturn of the ACA, how do you think you would be able to accomplish this objective?

Director CARROLL. Thank you. I am bipartisan on this issue. We have to save lives regardless, and providing treatment to everyone is critical to do this.

Ms. HILL. And to be clear, I am not making this about partisanship. I am concerned about what the courts are going to do, so I honestly want to know what is going to happen if the ACA is overturned.

Director CARROLL. In terms of first to talk about the Medicaid and the reimbursement, as well as health insurance, we have to make sure that it is sustainable going forward. So, to be able to give states the authority to help more at that level than at the Federal level to determine how they are going to provide treatment for people I think is critical.

One of the things we are also seeing is making sure for those people that do have insurance under the ACA—what we are seeing are co-pays that are so high that it is really not effective. There was a report this week that was talking about co-pays for individuals under some of the ACA plans. I think it is $6,000 or $8,000 per year, and $12,000 for families. At that point, you really have to wonder whether it is working or not.

Ms. HILL. Right. Well, in large part that is because of the increasing pressure we have seen from other attempts to undermine the ACA that the costs have gone up and co-pays have gone up exponentially.

But for me, I am wondering, and I do not know if this is possible to request, but I would love to see some contingency plans or other efforts from GAO and from your office on how such an overturn of the ACA would affect treatment.

Director CARROLL. I will see what we can get you as soon as possible.

Ms. HILL. Thank you.

With that, I would like to thank our witnesses so much for testifying today, and to you both who are still here, I was incredibly

moved by your testimony, and I am so sorry for your loss, and thank you, really, for bringing this to life in the halls of Congress.

Without objection, all members will have five legislative days within which to submit additional written questions for the witnesses to the Chair, which will be forwarded to the witnesses for their response. I ask our witnesses to please respond as promptly as you are able to.

And this hearing is adjourned.

[Whereupon, at 1:32 p.m., the committee was adjourned.]