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February 19, 2020

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone,

Thank you for the opportunity to testify before the Energy and Commerce Committee's Subcommittee on Oversight and Investigations January 14, 2020 hearing on "A Public Health Emergency: State Efforts to Curb the Opioid Crisis". Attached, please find answers to the additional questions from members of the Subcommittee. If you have any additional questions, please do not hesitate to reach out to me. Thank you again for this opportunity.

Sincerely,

Monica Bharel, MD, MPH
Commissioner
Department of Public Health

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Dr. Monica Bharel, Commissioner, Massachusetts Department of Public Health

The Honorable Brett Guthrie (R-KY)

1. *As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships? In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.*

   We have a number of examples to share. The Mass. Department of Public Health has worked closely with birth hospitals to implement the MA Perinatal-Neonatal Quality Improvement Network to improve services and treatment outcomes for substance exposed newborns. This initiative has brought together more than 30 Massachusetts hospitals, community groups, and state agencies in structured, collaborative improvement efforts, with over 300 health care providers participating in twice-yearly statewide summits that anchor the project.

   To better engage the obstetric and women's health communities, this network is also participating in the Alliance for Innovation on Maternal Health (AIM). AIM is a national organization focused on eliminating preventable maternal morbidity and mortality, including related to maternal opioid use disorder. By engaging Massachusetts hospitals in AIM, the network strives to align the obstetric community and birth hospitals to implement the AIM Opioid Bundle to improve overall maternal health outcomes and to address associated racial inequities in maternal morbidity and mortality associated with substance misuse.

   In response to Governor Baker's signing An Act Relative to Substance Abuse, Treatment, Education and Prevention (Chapter 52 of the Acts of 2016), the Department established mandatory monthly reporting of maternal drug dependence to opioid and benzodiazepines (F11.20 or F13.20) and newborn exposure (P04.49 or P96.1) requiring birth hospitals to report the number of infants born exposed to controlled substances. The Department has incorporated analysis of this monthly reporting in its quarterly opioid report (https://www.mass.gov/lists/current-opioid-statistics) shared publicly and with stakeholders.

Additionally, we are working to foster and support perinatal provider collaboratives focused on improving dyadic care for families affected by substance use disorders. These coalitions include medical, behavioral health, and other community providers as well as personnel from public state agencies. These partnerships improve coordination of care inter-department communication, and service quality improvement.

One way SAMHSA could partner with private entities to improve services, and service delivery, would be to foster innovative technologies to facilitate access to interventions for perinatal women with substance use disorders. An example of this is the federal Health Resources and Services Administration's Maternal and Child Health Bureau call for proposals to create technological innovations to assist in care and treatment of perinatal women with opioid use disorder. A recipient of the Innovation Prize funding created a mobile-accessible Plan of Safe Care platform. SAMHSA could replicate this style of competitive award to entice research organizations and tech companies to help develop innovative behavioral health products that could be piloted or disseminated in state agency or provider systems.

Additionally, SAMHSA could investigate ways to partner with housing entities – public and private – to develop opportunities for states to provide long-term and recovery oriented housing programs for women with children, and families.

In general whenever the federal government can allow braiding and blending of funds from different federal agencies across public agencies, including mental health and child welfare, this will allow us to enhance our care across the social determinants of health and the various needs of the individuals.

Massachusetts Public Health Data Warehouse (PHD) is a private/public data model that has informed and driven policy working to combat the opioid epidemic, and soon, other emerging public health priorities. We have collaborated with over 50 groups from across local, state, and federal government; academic institutions; healthcare delivery; and Consulting Agencies, Foundations, Private Companies, and Think Tanks. They helped us by providing data, subject matter expertise and analytic capacity which enabled the Department to execute a robust analytic agenda to inform Massachusetts' response to the opioid epidemic.

2. *Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?*

The short answer is no. Governor Baker has long requested that the impediments and unintentional barriers that have been created as a result of 42 CFR Part 2 be addressed. Treatment programs are able to share very limited information subject to 42 C.F.R. Part 2 (see response to question #3). Providers who want to share information regarding specific

patients with any person or entity must have a signed consent from the patient to release information which complies with 42 C.F.R. Part 2 and HIPAA. The consent form must be specific, include purpose, and include dates, signed and dated by the patient/client. Additionally, if providers want to share information with an external agency they must have a Qualified Service Organization Agreement in place which conforms to 42 C.F.R. Part 2. The limitations make it very difficult to engage in population health management and for Medicaid programs to provide complete data to providers to engage with individuals with complex medical and behavioral health conditions.

a. *Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?*

   Please see the response to question #3 regarding potential improvements to 42 C.F.R. Part 2 for care coordination and case management.

b. *Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?*

   We recommend changing the scheduling of naloxone in order to make it more widely available over-the-counter, without a prescription. We recommend revising the requirements for Medications for Opiate Use Disorder, particularly methadone therapy, to make it more accessible for patients and increase their continued compliance. Current federal methadone regulations have not been substantially changed in more than 30 years creating barriers through daily dosing requirements, limits to take-home medications, arbitrary time-in treatment requirements, and counseling requirements prior to receiving take-home doses. We further recommend that methadone therapy not be restricted primarily to stand alone clinics, but be integrated within primary care and other settings, including mental health and other substance misuse providers. Such barriers make long term compliance very difficult. Patients who have housing instability, lack of transportation, access to child care, or who are actively employed, are often unable to receive this evidence-based gold standard of treatment. By removing these barriers, access and continued compliance with treatment would be increased.

3. *Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?*

   Yes. In August 2019, SAMHSA requested comments to proposed amendments to 42 CFR Part 2. The overall aim of the amendments was to facilitate a more coordinated care

approach among providers who treat patients with SUD. As you can see from the attached comments submitted in October 2019, the Department expressed support for SAMHSA's goal of increasing the coordination of care while ensuring that privacy protections for patients seeking treatment for SUD remain in place. In general, although we are largely supportive of the proposed changes in the areas of re-disclosure requirements, consent to entities without a treating provider relationship, disclosures by OTPs to the PDMP, expansion of the medical emergency exception, alignment of the research exception with HIPAA, and clarification of the audit and evaluation exception, they do not go far enough.

There is one specific amendment that we believe hinders the goal of integrated care. Specifically, while the amendment clarifies what qualifies as "payment and health care operations" for purposes of written consent by the patient it does **not** include care coordination or case management under this definition. This is inconsistent with HIPAA which does include case management and care coordination under the umbrella of "health care operations." This inconsistency perpetuates unnecessary confusion among health care providers navigating the requirements of both Part 2 and HIPAA. More substantively, restrictions on disclosure for case coordination and case management services present obstacles for providers to provide the full continuum of care necessary for SUD patients. Ideally, there should only be one privacy law rather than two.

4. *In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?*

In November 2019 the Massachusetts Department of Public Health announced the availability of funding to build upon the existing work of the Massachusetts Opioid Addiction Prevention Collaborative (MOAPC) and Substance Abuse Prevention Collaborative (SAPC) currently taking place in community clusters across the Commonwealth. These collaboratives were asked to submit proposals to support or expand one existing strategy currently in place in a single community or across a cluster, that addressed needs of at least one of the following DPH priority populations:

People with a history of substance use disorder and-

- who have co-occurring mental health
- who are incarcerated or have a history of incarceration
- who are experiencing (or have a history of) homelessness or housing instability
- Pregnant and post-partum women
- Communities of color
- Occupations at high risk of overdose and death from opioids (i.e. construction industry)
- Individuals who have experienced a non-fatal overdose

- Other high risk groups as locally identified

Twenty out of 28 eligible communities applied for funding available through the 20 percent prevention funds set aside, and all were funded to implement local strategies aimed at reducing fatal and non-fatal overdose in at least one of the high risk populations identified in the application, with a start date of July 1, 2020.

5. *How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?*

   Since its creation in 2013, the Massachusetts Opioid Overdose Prevention Collaborative (MOAPC) enlisted a portion of the prevention funds set aside from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) from SAMHSA to fund grantees across the Commonwealth to implement local policy, practice, systems, and environmental change to: (1) prevent the misuse of opioids and (2) prevent/reduce fatal and non-fatal opioid overdoses.

   MOAPC's include mayors/town managers, boards of public health, substance abuse prevention and treatment providers; narcan pilot sites and other BSAS-funded overdose prevention and treatment programs (as available); local/regional hospitals; representatives from the criminal justice system; public safety and first responders; consumers of substance abuse treatment services; community members including youth, parents, and social service agencies.

   MOAPC consumption strategies for the prevention of opioid misuse and prevention/reduction of fatal and non-fatal opioid overdoses include: prescriber/dispenser education; community awareness/knowledge/norms; safe storage and disposal; parent information; prescription recipient information; school athlete awareness/knowledge/norms; school-based health curricula; and youth awareness/knowledge/norms. Consequence strategies include: overdose risk, recognition, and response training with at-risk populations; increasing access to naloxone; overdose risk, recognition, and response information; awareness of the Good Samaritan Law; reducing barriers to calling 911; and promoting linkages to treatment.

   Additionally, through the SAMHSA grant, we have created Partnership for Success 2015 (PFS 2015), which funds 16 high need communities impacted disproportionately by the opioid crisis to prevent prescription drug misuse and abuse among high school aged youth. Examples include: education to parents about the risks of opioid prescriptions, help for them to engage in conversations with their kids, prescription safe storage and disposal, public education, and local campaigns about the risks of prescription drugs etc. Outcomes for the PFS 2015 include:

- Enhanced community infrastructure to address prescription drug misuse and abuse among high school aged youth (e.g., more diverse partnerships and stakeholders participating in prevention activities).
- Increased knowledge among prescribers of the dangers of over-prescribing opioids (e.g., provider/prescriber training)
- Increased awareness among parents/caregivers, student athletes, and coaches of the need to monitor the use of prescription medications following sports injuries (e.g., opioid misuse prevention student athletes packet).
- Increased community participation in national DEA drug take-back days and associated activities.
- Reductions in home-based access to prescription medications for the purpose of misuse due to safer storage and disposal practices.
- Increased discussions between parents/caregivers and their children about the dangers of misusing/abusing prescription medications.

In addition to the above, we use a data-driven approach to help inform local communities of the changes in the opioid epidemic in all 351 towns and cities in MA. This includes quarterly reports that break down the opioid overdose deaths by town and city and hotspot mapping to show areas of increase and decrease in overdose activity.

6. *How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?*

   The Department of Public Health Massachusetts Opioid Overdose Prevention Collaborative (MOAPC) grantees are clusters of communities in which a lead municipality applied as the lead applicant in collaboration with 2-4 other neighboring municipalities in their region, (2) counties or public health districts comprised of multiple municipalities, and (3) large individual municipalities with a population over 150,000. An additional requirement is that the applicant needed to have an individual or combined average of 30 or more cases per year of unintentional deaths and non-fatal hospital events associated with opioid poisonings during the three-year period prior to the writing of the application. Priority was given to clusters that strengthened Public Health Districts, built upon existing collaborations, and encouraged new or expanded collaborations in coordination with local municipalities. Currently, there are 19 lead MOAPC grantees and 99 partner municipalities – 116 total municipalities. The lead community has discretion on how to allocate resources among the members of the cluster. This ranges from instances in which all members of the cluster share these resources equally to instances in which resource allocation within the cluster is based on need, capacity, and strategies being implemented.

   We partner with the Police Assisted Addiction and Recovery Initiative (PAARI), a community policing movement focused on creating non-arrest pathways to treatment and

recovery. By creating entry points to treatment, PAARI is working toward a vision where non-arrest diversion programs become a standard community policing practice across the country, reducing overdose deaths, expanding access to treatment, improving public safety, diverting people away from the criminal justice system, and increasing trust between law enforcement and their communities.

MDPH funds Learn to Cope, a non-profit support network that offers education, resources, peer support, and hope for parents and family members coping with loved ones who are addicted to opiates or other drugs. Learn to Cope collaborates with communities across the state to spread messages of prevention, education, awareness, and advocacy. Learn to Cope was the first parent network in the country to provide the nasal Naloxone, and many of its group meeting facilitators are trained and certified to provide overdose education and nasal naloxone kits at each chapter.

Overdose Education and Naloxone Distribution (OEND) is the result of joint public health system and community advocate efforts, including collaboration between MDPH's Office of HIV/AIDS, the Bureau of Substance Addiction Services, community HIV prevention programs, substance use treatment programs, syringe service providers, and hospital emergency departments. Program services include issuance of standing orders for trained nonmedical public health workers to train and distribute nasal naloxone to potential opioid overdose bystanders, providing nasal naloxone, mucosal atomizers, and educational materials to agencies for distribution, and working through community meetings, street outreach, home delivery, and homeless shelters.

Massachusetts' Center for Strategic Prevention Support (CSPS), formerly the MA Technical Assistance Partnership for Prevention (MassTAPP/State TA Center) guides DPH-funded prevention programs across the Commonwealth through an evidence based five-phase Strategic Prevention Framework process. It provides individualized technical assistance; expert consultant services; online learning events (e.g., webinars); in-person events (e.g., regional meetings, quarterly meetings, and an annual statewide conference); peer-to-peer learning; and a website and monthly electronic newsletter.

7. *We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?*

In Massachusetts, we are working to address the workforce development needs for professionals treating substance use disorder. Some examples of our efforts include:

1. Medical student core competencies and DATA waiver training during medical school: during my testimony I mentioned that Massachusetts was the first state to have all of our medical schools agree on a set of core competencies for medical

student training. (published competencies in Academic Medicine) These core competencies were then adopted by all dental schools, advanced practice nursing,, physician assistant, social worker and physical therapy programs across the state. Additionally all medical schools now provide the required DATA waiver training for buprenorphine to graduating medical students. We welcome an opportunity to assist in making this model consistent across training throughout the country.

2. Recovery coaches -we have developed training programs for recovery coaches and recovery coach supervisors. We have successfully piloted recovery coach services being embedded in emergency departments; now a benefit covered by MA Medicaid.
3. Licensed Alcohol and Drug Abuse Counselors-
   Increasing the number of Licensed Alcohol and Drug Abuse Counselors in areas of highest need: we fund the cost of participants for the Black Addiction Counselor Education and Latinx Addiction Counselor Education programs (both currently run through AdCare Educational Institute). BSAS also works with our Healthcare Workforce Center to ensure that Licensed Alcohol and Drug Abuse Counselors and other behavioral health professionals apply for and receive (when eligible) loan repayment opportunities through the federally funded Mass Loan Repayment Program.

Overall increased training and education: Through partnerships with organizations such as AdCare Educational Institute, Praxis, Institute for Health & Recovery, and Health Resources in Action, we provides SUD prevention, intervention, treatment, and recovery related training, which are open to anyone working within the system. These trainings are also available to anyone in other human services sectors, such as Massachusetts' Department of Children and Families, Department of Mental Health, Department of Corrections, and Department of Youth Services.

Loan repayment and other incentives to work with highest risk populations are also needed. As are incentives for non –English services, sign language services and communities with less access to care.

8. *The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?*

   a. How much has your state received and spent on its PDMP to date?

      To date, the PDMP has received $3,628,000 in Federal support, of which $2,526,000 has been spent.

   b. Is there any data or reports that detail the positive outcomes from utilizing a PDMP?

The PDMP is used so that a prescribers and pharmacists are able to see a patient's prescription record outside of his/her own limited network. Between CY 2013 and CY 2019, there has been a 61% reduction in the number of individuals who have received a Schedule II opioid prescription from 4 or more prescribers, involving 4 or more pharmacies in a 90 day period. The majority of the individuals who continue to trip this threshold do so because of a complex medical condition.

In 2016, Governor Baker signed legislation that limited the number of days that a physician could write a prescription. We believe this legislation, in conjunction with the mandate that prescribers utilize the PDMP, accounts for Schedule II opioid prescriptions falling by over 40% in MA.

The PDMP is an extremely valuable source of data that can be used to inform individual practitioners and the healthcare community. We provide quarterly reports to prescribers comparing their prescribing patterns to their peers in four drug categories: opioids, sedatives, stimulants, and OUD treatment drugs (e.g., Suboxone). From survey data we know that these reports serve as a basis for reflection and change in prescribing practices.

The publication of county and city and town prescription trend analyses is another source of valuable data for researchers and for the healthcare community.

9. *Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?*

Massachusetts has completely overhauled its PDMP. Massachusetts pharmacies submit prescription records within 24 hours or the next business day, and these records are posted within seconds to the PDMP. Although not real-time, the PDMP provides accurate and timely information to practitioners and pharmacists. MA PDMP users have access to **39** states and U.S. Territories, the District of Columbia, and the Military Health System. One area of concern is the interstate access for providers who have integrated PDMP data into their EHR systems. There are several barriers for these integrated providers. First, integrated providers are treated as individual entities divorced from their state PDMP. Certain states allowed providers to integrate without state audit controls that ensure that end users are registered with their state PDMP, and that each search can be identified and tracked by the state PDMP. Secondly, the security of the API used for integration can be in question. MA requires one of a small number of APIs that have been approved by the Department's IT security team. Finally, there are statutory barriers (e.g. NH), that allow sharing data with only other state PDMPs. These barriers, it is important to note, would not be overcome by the promotion of the BJA sponsored data sharing hub, RxCheck, which has its own set of security and functionality issues to address.

a. *If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense?*

   Although not ideal, there are workarounds. the prescriber at a MA hospital looking for data on a patient from another state, will not have access to the patient's out of state records through the patient's EHR, but can query that patient from MassPAT, the web-based PDMP.

b. *If so, how can we address these problems and improve PDMPs?*

   Additional education and uniform security protocols will help. Already we are seeing EHR vendors code to APIs that are approved by MA.

10. *Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?*

    Yes. MA meets or exceeds National Institute of Standards and Technology (NIST) guidelines for the transmission of electronic protected health information (EPHI) as required by the HIPAA security rule.

11. *Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?*

    Please see the response to #9 above.

    a. *Would states having the ability to access information across all state lines assist in fighting the epidemic?*

       One national database as the data set for all PDMPs might create more problems but we would need to understand more about the details. For example, the larger the data set, the more likely an individual might have his or her prescription records merged incorrectly in a patient report. Patient matching algorithms have and are continuing to improve, however, short of collecting and transmitting identifiers such as the individual's social security number, these will remain imperfect.

       The MA PDMP has a high utilization rate because it is a valuable clinical tool. High utilization promotes safe prescribing and dispensing. The potential of a mismatch,

and therefore inaccurate data, would undermine confidence in the effectiveness of the PDMP to recognize and to prevent SUD.

12. *What were the circumstances that you believe led to the opioid crisis in your state?*

    As in other states, Massachusetts experienced very significant increases in prescribing of opioids for acute and chronic pain over a number of years. Soon afterward, we identified the increased availability of heroin in our state. Subsequently, synthetic opioids (such as fentanyl) became far more prevalent in the illicit drug supply, leading to an increase in opioid overdoses and overdose deaths.

13. *How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?*

    MDPH utilizes a multi-pronged contract oversight and management system that ensures the appropriate and authorized use of funds. First, the state uses a competitive, public, and transparent procurement process to select community-based entities, including non-governmental organizations, non-profits, treatment centers, and others to serve as sub-recipient partners on federal grant awards. MDPH frames the details of procurements based on the requirements of the funding opportunity, including stating special terms and conditions of award around the authorized use of funds. (Detailed information about the procurement process is provided on the "Doing Business with DPH" website: https://www.mass.gov/ info-details/doing-business-with-dph).

    Once vendors are selected, they are engaged through a contracting process that again outlines the terms, conditions and requirements of the award from both programmatic and fiscal perspectives. As part of implementation oversight, ongoing regular meetings are held, both by phone and in-person, with all sub-recipients to manage and monitor performance, adherence to requirements, and progress towards achieving goals. With regards to fiscal monitoring, vendors submit monthly invoices detailing expenditures based on standard budget and billing categories. State contract and fiscal managers review all billing and invoicing prior to approving payment, and periodic fiscal reviews or audits are conducted as needed or required. This close monitoring ensures compliance with the requirements of the funding, mitigates risk, and supports successful implementation.

14. *How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?*

    In 2015, one of Governor Baker's first actions upon taking office was to appoint a 16·-member working group, chaired by his Secretary of Health and Human Services, and tasked

with identifying short and long term strategies to respond to the opioid crisis. By holding public meetings, assessing the resources devoted to the problem, and submitting recommendations, an Action Plan was developed that serves as a blueprint for addressing the opioid crisis in the state (https://www.mass.gov/lists/governors-opioid-addiction-working-group). A key strategy outlined by the working group was to utilize data to identify hot spots and deploy appropriate resources.

The Commonwealth has prioritized linking data sets across government agencies (e.g. medical claims, death records, ambulance trips, post-mortem toxicology, prescription drug monitoring program, the Department of Mental Health, birth records, the Department of Correction, Houses of Correction, and the Department of Veteran's Services) to better understand the opioid epidemic, guide policy development, and help make programmatic decisions (www.chapter55.digital.mass.gov; www.mass.gov/public-health-data-warehouse-phd). Additionally, MDPH produces quarterly reports on opioid overdose related deaths in the Commonwealth overall, by county, city/town, and based on population demographics. Localities most impacted by the opioid crisis in the state can be found on this website: www.mass.gov/lists/current-opioid-statistics. These tools allow tracking of current opioid morbidity and mortality trends, thereby allowing MDPH to identify areas of most concern and inform and guide strategy and resources.

Through these efforts, we have targeted attention to the following priority populations:

- **Persons with history of incarceration**: analysis of statewide data has found that "compared to the rest of the adult population, the opioid-related overdose death rate is 120 times higher for persons released from Massachusetts prisons and jails
- **Persons with co-occurring disorders**: State data indicates that the risk of fatal opioid overdose is six times higher for persons diagnosed with a serious mental illness (SMI) and three times higher for those diagnosed with depression.
- **Veterans**: The percentage of identified veterans who had a fatal opioid-related overdose was three times the state average.
- **Individuals experiencing homelessness**: The opioid-related overdose death rate is 16 to 30 times higher for homeless individuals compared to the rest of the adult population.
- **Persons who use multiple substances**: The percent of opioid-related overdose deaths involving cocaine and fentanyl but without likely heroin is increasing across all races.
- **Pregnant and parenting women**: Among women of child-bearing age, the number of opioid related deaths in MA increased from 9.6 deaths per 100,000 females in 2012, to 12.8 deaths per 100,000 in 2013. The state's child welfare agency reported a 13.5% increase in allegations of a substance exposed newborn from 2015 to 2016.
- **Persons Who Inject Drugs**: Preliminary data indicates that in 2017 the proportion of HIV infection among PWID increased to approximately 15% of reported cases, up from an average of 4-8% in previous years.

Examples of our data briefs and quarterly reports can be found at mass.gov/opioidresponse and a few examples at below links:

- Legislative Report: Chapter 55 Opioid Overdose Study - August 2017 PDF
- Legislative Report: Chapter 55 Opioid Overdose Study - September 2016 PDF
- Opioid and Stimulant Data Brief March 2019
- Data Brief: Chapter 55 Opioid Overdose Study - August 2017 PDF
- Data Brief: Chapter 55 Opioid Overdose Study - September 2016 PDF

The Honorable Bob Latta (R-OH)

1. *In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?*

   Since 2015, the Department has received the following in addition to STR and SOR:

   SAMHSA funding:
   1. 2015-2018: Medication Assisted Treatment-Prescription Drug and Opioid Addiction
   2. 2015-2018: State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Implementation
   3. 2015-2020: Strategic Prevention Framework
   4. 2018-2021: MAT-PDOA (second round)
   5. Ongoing, annual, non-competitive funding: Substance Abuse Prevention and Treatment Block grant

   CDC funding:
   1. 2016-2019: Prescription Drug Overdose Prevention for States (PDO PfS)
   2. 2016-2019: Enhanced State Opioid Overdose Surveillance (ESOOS)
   3. 2018-2019: Emergency Response: Public Health Crisis Response-Opioid Overdose Crisis
   4. 2019-2022: Overdose Data to Action (OD2A)

2. *I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?*

   The administrative burden for submitting grant applications with varying timelines and requirements can be substantial. A significant amount of oversight, coordination, and planning is necessary for the successful management of new grant submissions, as well as ongoing oversight and management of funded grants from both the programmatic and fiscal perspectives. When federal grants have differing timelines and requirements, it can create risk and vulnerability for states that have limited administrative capacity to meet multiple competing federal grant deadlines simultaneously, in addition to addressing state level

priorities. Federal grant writing and budgeting is an acquired skill, so when application requirements differ qualified staff are needed to respond yet can be challenging to identify, and new staff must be trained which can take time. This is especially important in an environment where funding is awarded competitively.

a. *Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?*

Yes, standardizing the submission processes and application requirements would be helpful in reducing the administrative burden and in streamlining the submission process. Specifically, the format for the grant program narrative, budget justification and the required supporting documentation all differ by agency and by grant program within agencies (e.g., SAMHSA, CDC, NIH, HRSA, etc.), and require prior knowledge and acquired skills to successfully complete in a competitive grant environment. If federal grant applications all had the same core standard sections and subsections, less specialized training and skill development would be needed and the administrative burden would be reduced.

With regard to the submission process, currently, new federal grant applications can be submitted through either eRA Commons or through grants.gov. Having two separate submission systems with similar functionality can cause confusion and a duplication of efforts, and can hinder a state's ability to develop standardized operating procedures for submitting federal grants.

Thank you for the opportunity to address these questions.