Diversified Reporting Services, Inc.

RPTS BRENNAN

HIF172140

RESPONDING TO AMERICA'S OVERDOSE CRISIS: AN EXAMINATION OF LEGISLATION TO BUILD UPON THE SUPPORT ACT

WEDNESDAY, JUNE 21, 2023

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:03 a.m. in Room 2322 of the Rayburn House Office Building, Hon. Brett Guthrie [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Johnson, Bucshon, Hudson, Carter, Dunn, Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio); Eshoo, Cardenas, Ruiz, Dingell, Kuster,

Kelly, Craig, Schrier, Trahan, and Pallone (ex officio).

Also present: Representatives Balderson; Schakowsky, and Tonko.

Staff Present: Sean Brebbia, Chief Counsel, Oversight and Investigation; Jolie Brochin, Clerk, Health; Kristin Flukey, Professional Staff Member, Health; Seth Gold, Professional Staff Member, Health; Grace Graham, Chief Counsel, Health; Tara Hupman, Chief Counsel; Emily King, Member Services Director; Chris Krepich, Press Secretary; Molly Lolli, Counsel, Health; Carla Rafael, Senior Staff Assistant; Michael Taggart, Policy Director;

*Mr. Guthrie. The subcommittee will come to order, and the chair recognizes himself for five minutes for an opening statement.

Today we are here to examine the SUPPORT Act and how its implementation has helped increase access to prevention, treatment, and recovery services. Since the passage of the SUPPORT Act there have been several efforts to address issues related to substance use disorder and drug overdoses, which include Restoring Hope for Mental Health and Well-Being Act and the HALT Fentanyl Act. This hearing will give us the opportunity to see what legislation solutions have been working and address any potential gaps.

Earlier this month we convened a field hearing in Gettysburg, Pennsylvania, where we had the opportunity to hear from addiction experts to learn about how policies from the SUPPORT Act have helped in the fight against drug overdoses. We heard heart-wrenching testimony from Michael Straley, who lost his daughter Leah, on Valentine's Day a few years ago to fentanyl poisoning. Tragically, there are hundreds of thousands of stories like Michael's.

In just the past 2 years more than 200,000 Americans

have tragically lost their lives to drug overdoses driven by synthetic opioids such as illicit fentanyl. In Kentucky, over 70 percent of all drug overdoses are caused by illicit fentanyl. The evidence is clear that we have more work to do to effectively curb historically high drug overdose rates, and it is more important than ever that this committee recommit to addressing this crisis.

Key to ensuring success will be a focus on prevention efforts. One example of legislation we are considering today would address the threat of Xylazine, a tranquilizer routinely used for animals that is quickly becoming one of the deadliest street drugs. H.R. 1839, the Combat Illicit Xylazine Act, led by Representative Pfluger, would subject individuals who distribute these substances illegally to schedule III penalties.

To supplement this work we are considering legislation to allow Federal funding to be used for fentanyl and Xylazine testing strips in states where they are legal, and to help ensure that all FDA-approved overdose reversal medications [sic].

Prevention, however, must be coupled with policies that

promote access to care to help those who are currently struggling with addiction. That is why we are considering legislation today that will provide access to reliable care for vulnerable populations, including providing for medication-assisted treatment for Medicaid patients and treatment services for foster care youth and for pregnant or postpartum women.

Of note, H.R. 3892, the Improving Mental Health and Drug Treatment Act, will lift the IMD exclusion for residential and inpatient services. The exclusion, which arbitrarily limits access to residential care facilities with 16 or fewer beds, has been a significant barrier to care for vulnerable populations, including homeless populations and children that are currently being boarded and treated in emergency departments for severe mental illness and substance use disorder, rather than able to get care in a clinically appropriate setting. The legislation will ensure patients are receiving the most appropriate and comprehensive care to address their needs.

Thank you to Dr. Burgess for your historic leadership on this important issue, and I look forward to moving this bill

forward.

We are also examining solutions that will promote long-term recovery and wrap-around services to support individuals' journey to rehabilitate their lives. This includes my bill, H.R. 1502, the Comprehensive Opioid Recovery Centers Reauthorization Act, which reauthorizes the Comprehensive Opioid Recovery Centers Program for five years. The CORCs program is responsible for providing wrap-around treatment and recovery support services, including workforce training, to individuals living in communities with disproportionately drug overdose rates.

I am proud of the early results of this program, and I would like to thank Representatives Tonko, Bucshon, and Peters for their partnership on this issue.

Before I close I would like to touch on bills before us that would attempt to support the behavioral health needs of those moving in and out of the criminal justice system. There is more we need to do to address access to the care for these individuals so they can get the right care as they re-enter the communities. We are looking at two proposals before us today in their current form. We need to make sure

we don't do massive cost-shifting from state spending to Federal spending without first solving the problems at hand. So we need to look carefully at the two bills before us today that do that.

I look forward to identifying long-term solutions that are fiscally responsible and empower states to provide access for care to incarcerated individuals. I look forward to continuing the process to reauthorize the SUPPORT Act, and I thank my colleagues for leading on these bipartisan policies.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. And I yield back, and will recognize the ranking member of the subcommittee, Ranking Member Eshoo, for five minutes for her opening statement.

*Ms. Eshoo. Good morning, Mr. Chairman, and thank you for yielding to me.

Good morning to our witnesses. Thank you for being here today.

Over one million Americans died from COVID. Over 1 million Americans have died from a drug overdose since 2000, including nearly 110,000 overdose deaths in just the last year. About 300 Americans die every day from a drug overdose. These are jaw-dropping figures.

Our country has had three waves of opioid deaths caused by prescription opioids, heroin, and now illicit fentanyl. According to the CDC, fentanyl poisoning caused 68 percent of the overdose deaths in the past year.

Today our subcommittee considers 28 mostly bipartisan bills to build on the 2018 SUPPORT Act to address the opioid crisis by increasing access to treatment and improving overdose prevention efforts.

To -- I am sorry -- a major contributing factor to

overdoses is difficulty finding treatment. According to SAMHSA, only 11 percent of people in our country with opioid use disorder receive medication-assisted treatment. People in jails and prisons are frequently denied treatment because of lack of Medicaid coverage while incarcerated. People who are released from jail and prisons are 12 times more likely to die of an overdose than the general public. Bills by Representatives Trone and Tonko address these inequities by expanding Medicaid coverage during pre-trial and the month before release.

Another barrier to accessing treatment is -- are the shortages of qualified health providers. According to HRSA, more than 150 million Americans -- 150 million Americans, that is almost half of our population -- live in mental health provider shortage areas, where the number of local providers cannot meet the area's need for substance use treatment. To address these shortages, we will consider legislation to continue grant programs for opioid recovery centers, peer support workers, and specialized treatment for pregnant and postpartum women with substance use disorders, as well as for children recovering from trauma.

We are also considering legislation to reform the institutions for mental diseases exclusion, which restricts Medicaid coverage for residential and inpatient behavioral health services to facilities with fewer than 16 beds.

California, my home state, is currently benefiting from a waiver to the IMD exclusion, and is receiving Federal funding to support quality inpatient treatment for substance use disorder.

Unintentional exposure to highly potent and fast-acting fentanyl is driving overdose deaths. We know this. To help prevent overdoses, we are considering the Test Strip Access Act to provide access to strips that test drugs for deadly chemicals like fentanyl and Xylazine.

I look forward to hearing from each one of our witnesses today from the CDC, CMS, HRSA -- it is a real alphabet soup at the table -- CDC, CMS, HRSA, SAMHSA, and the DEA about their whole-of-government effort to prevent overdose deaths, and your recommendations for what else Congress should do to save lives. It is really a tall order, but it must be addressed. These statistics are really shameful. So thank you.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. And I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentlelady yields back. I now recognize the chair of the full committee, Chair Rodgers, for five minutes for her opening statement.

*The Chair. Thank you, Mr. Chairman.

Today we continue our work to address the opioid crisis, as well as the despair addiction and increased suicides, as the ranking member just said, to save lives.

This Congress this committee has taken decisive actions to keep Americans safe from the threats of illegal drugs. We held two roundtables on the role that illicit fentanyl has played in driving up overdoses and poisonings. We have had Biden Administration officials testify on the crisis at the first Health Subcommittee hearing of this Congress. We held a field hearing in Pennsylvania, where we heard from local law enforcement and providers who are on the front lines of responding to this crisis, and lead on the HALT Fentanyl Act, which passed the House with strong bipartisan vote.

And now it is time that we turn to strengthening the SUPPORT Act, landmark legislation signed into law to bolster treatment and recovery initiatives, improve prevention, and

fight fentanyl.

When this committee led the way on the SUPPORT Act 5 years ago, there were about 70,000 overdose deaths per year, driven by prescription opioids and other narcotics like heroin. Since then, even though Congress has appropriated more than $20 billion to states for the substance use block grant and the state opioid response block grant, the crisis has only gotten worse. The government enforced COVID-19 lockdowns, sent millions of Americans who were on the road to recovery backwards.

Additionally, the pandemic sent more people into despair and isolation, driving them to take up illicit drugs for the first time. We also saw a dramatic shift in the causes of overdoses from prescription opioids to fentanyl poisonings, and now other substances like tranqs. Together, these caused overdose deaths to spike more than to 100,000 deaths per year, more people than ever.

In my home state, overdose deaths have increased by 108 percent just since 2019. It is the second largest increase in the country.

To save lives and to give people hope, we must address

the root causes of this crisis. We need to cut off the supply of illegal drugs and hold traffickers accountable. We need to better warn Americans and young people that any drug could be laced with fentanyl. We need to increase treatment options for people in need, and we need to help those in recovery stay on track and fully participate in their communities.

Many of our bills will build on what has worked to improve access to care. This includes the Protecting Moms and Infants Reauthorization Act, led by Representative Kim, to continue support for residential substance use disorder treatment services for pregnant and postpartum women.

The Safer Response Act, led by Representative D'Espinosa, would continue support for training related to fentanyl and other illicit substances for first responders.

The Reconnect Act, led by Representative Griffith, would continue support for the improvement of prescription drug monitoring programs and other innovative projects related to rapid response of controlled substance misuse and overdoses.

I also believe it is important to permanently lift Medicaid's IMD exclusion so that we do not arbitrarily limit

access to care for those who need it most. Advocates from every level of state and local government, as well as key associations that represent people with substance use disorder and mental health needs, support lifting the IMD exclusion, as well. These supporters recognize that when a patient needs help and is ready to seek treatment, we should not be denying them support at the level of care that works best for them. It is time to end this prohibition once and for all.

Before I close, I would like to note my concerns on the Reentry Act and the Due Process Continuity of Care Act. I support the goal of ensuring people who are incarcerated have the tools to safely reenter their communities and get the care they need. This is why I have supported policies in the past, like from Congressman Hudson, that helped children who are incarcerated receive necessary treatments. However, I have reservations about the bills in their current forms, and believe that we need to know first what barriers exist for states, localities, and the Bureau of Prisons from providing care which they are all required to do.

Overall, I want to thank you, thank all my colleagues

who are leading on solutions today. This crisis has hit every community. We all know people and families who need to be rescued from despair. And for them we must keep working together to ensure these solutions provide the support and tools that people need to find meaning, purpose, and the chance for a better life. That is how we restore hope and bring healing across America.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. Thank you, I yield back.

*Mr. Guthrie. Thank you. The chair yields back. I now recognize the ranking member of the full committee, Mr. Pallone from New Jersey, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman.

In 2018 this committee came together in strong bipartisan fashion to pass the SUPPORT Act to address the ongoing opioid epidemic. Over the last five years, this law has expanded treatment options in Medicare and Medicaid; allowed more providers to prescribe medication-assisted treatment; and made important investments in public health.

Today we are considering a number of bills to help further address the ongoing opioid epidemic, including bills to reauthorize critical programs included in the SUPPORT Act. Ongoing action is necessary because, tragically, nearly 110,000 Americans died last year of drug overdoses. I am especially hopeful that this will be the year that we are able to move H.R. 2400, the Medicaid Reentry Act, out of the committee and have it signed into law.

This bill would build on the bipartisan work we did last

Congress by enabling eligible individuals to enroll in Medicaid 30 days prior to their release from incarceration. Researchers have found that people recently released from incarceration are 10 times more likely to overdose on opioids than the general public. Many times these individuals can struggle to access care upon their release, making them more likely to delay seeking treatment.

Allowing eligible people to enroll in Medicaid prior to their release will help connect them to coverage upon their discharge. This will help smooth their transition back into the community because they are able to access the services they need. I hope we can finally move this bill forward and give states the tools they need to support incarcerated individuals in recovery.

I am also pleased that we are considering bipartisan legislation that would reauthorize several important provisions from the SUPPORT Act that strengthen the ability of communities to respond to the opioid epidemic. We will be discussing bills to reauthorize programs to train first responders, support recovery centers, and bolster the behavioral health workforce.

Other programs up for reauthorization would expand treatment for pregnant and postpartum women, connect schools with mental health services, and continue an important task force on trauma care.

We will also consider legislation to expand access to lifesaving resources such as fentanyl and Xylazine test strips, and to have HHS and DEA re-examine the evidence regarding the important treatment options like Suboxone. I don't know if I am pronouncing this correctly. Together, these bills will help us combat the opioid epidemic.

I am hopeful that these bipartisan policies can move through our committee process, but I am disappointed that the majority has also chosen to include several bills that are problematic. I am particularly concerned about proposals that would create financial incentives to institutionalize individuals with substance use disorders. Rather than simply warehousing these individuals, Congress should provide states with the resources to expand provider capacity and expand access to services in home and community-based settings.

I am also -- I also question why we are considering legislation that would permanently extend the option for

states to cover short-term stays in an institution for mental disease, or IMD. I was skeptical of this policy when it was passed five years ago. In the years since, the response from states has been underwhelming. Currently, I am aware of only two states that have taken up this option. We should acknowledge that this policy has not lived up to the expectations of its supporters, and not look to permanently extend it.

I have also concerns with H.R. 824, which would allow employers to offer telehealth as a separate, standalone policy exempt from the Affordable Care Act's critical consumer protections. I believe this bill is a solution in search of a problem. Employers already have the flexibility to offer telehealth to their employees. I am concerned that this bill would instead expand a form of insurance that is not subject to the ACA's consumer protections.

These insurance plans are also not subject to mental health parity, and can be deceptively marketed to Americans as comprehensive coverage. I worry that if we expand these plans, American families will be left with inadequate coverage and at risk of surprise medical bills.

And finally, I am troubled by the inclusion of H.R. 1839, the Combating Illicit Xylazine Act. I understand that Xylazine is a growing problem. Doing an end run around the interagency process for scheduling controlled substances is not the answer. I am concerned about the precedent of Congress attaching criminal penalties to a drug that is not scheduled.

I understand that access to legitimate veterinary and agricultural uses of Xylazine needs to be preserved. But this should not -- this should be handled through the administrative process, not by Congress picking and choosing drugs to apply criminal penalties to -- by statute.

Now, everyone in this room is far too familiar with the tragic consequences of the opioid epidemic. While we have seen some improvements, there is still a long way to go, and I am hopeful that we will be able to find bipartisan solutions to ensure that our states, cities, and first responders have the resources they need.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentleman yields back, and that concludes opening statements. We will now move to our witnesses' opening statements.

All of you have testified before. You have five minutes for your opening statement, and there will be a yellow light, one minute, and so -- kind of rounding up, and then after red it means your time has expired.

I will introduce our witnesses together, and then I will go back and call on each one of you individually to do your testimony.

First we have Mr. Matthew Strait, deputy assistant administrator for the DEA Office of Diversion Control.

Dr. Christopher Jones, director of the National Center for Injury Prevention and Control for the CDC.

We have Mr. Tom Coderre, acting deputy assistant secretary for mental health and substance abuse.

Ms. Diana Espinosa, a principal deputy administrator of the Health and Human Health Resources and Services Administration, and acting deputy assistant secretary for mental health and substance abuse.

And Mr. Jonathan Blum, the principal deputy administrator and chief operating officer for the Centers for Medicare and Medicaid Services.

So thank you all for being here. We look forward to your testimony.

And Mr. Strait, you are recognized for five minutes for your opening statement.

STATEMENT OF MATTHEW STRAIT, DEPUTY ASSISTANT ADMINISTRATOR, OFFICE OF DIVERSION CONTROL FOR THE DRUG ENFORCEMENT ADMINISTRATION; CHRISTOPHER JONES, PHARMD, DRPH, MPH, DIRECTOR OF THE NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION; TOM CODERRE, ACTING DEPUTY ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE; DIANA ESPINOSA, MPP, PRINCIPAL DEPUTY ADMINISTRATOR OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION, ACTING DEPUTY ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE; AND JONATHAN BLUM, MPP, PRINCIPAL DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER FOR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

STATEMENT OF MATTHEW STRAIT

*Mr. Strait. Full committee Chairman McMorris Rodgers, Chairman Guthrie, ranking member of the full committee, Mr. Pallone, and Ranking Member Eshoo, and distinguished members of the committee, on behalf of DEA Administrator Anne Milgram and the nearly 10,000 men and women of the Drug Enforcement Administration, I am honored to be here today to discuss

DEA's efforts to implement important changes to the Controlled Substances Act resulting from passage of the SUPPORT Act.

The latest provisional overdose death statistics from our partners at CDC show that the U.S. lost an estimated 109,680 Americans for the 12-month period ending in December of 2022. Fentanyl is involved in roughly two-thirds of those deaths, and we refer to these deaths as poisonings because illicit fentanyl is a poison. I am reminded of this every day as I pass through the halls of DEA, where we have displayed the images of more than 2,600 Americans lost. These individuals are the faces of fentanyl.

These poisons are being produced primarily in the -- by the Sinaloa and Jalisco cartels in the form of fake pills. According to DEA's forensic analysis of seized pills, 6 of 10 contain a lethal dose. The appearance of Xylazine, an animal tranquilizer encountered in 48 states, adds complexity to our response and increases harm to users.

While Naloxone can reverse the respiratory depressive effects of fentanyl, it will not reverse the same effects produced by Xylazine. Fentanyl mixed with Xylazine is an

emerging threat in the United States, and is the reason why we must place schedule I controls on fentanyl-related substances and improve regulations for Xylazine.

The simple fact is that any pill which a person obtains outside of a licensed pharmacy could contain a lethal dose of fentanyl, could contain a lethal dose of methamphetamine, cocaine, or a combination thereof. Teens who order a pill on a smartphone, college students who take a pill from a friend, elderly neighbors searching online for a painkiller, or patients who develop the disease of addiction, these vulnerable Americans are victims of predatory criminal drug networks.

Within the DEA, the Diversion Control Division, where I have spent the majority of my 24-year career, is responsible for preventing, detecting, and investigating the diversion of controlled prescription medications from our more than two million registrants. Beyond this essential role of protecting the safety of Americans from the improper prescribing and misuse of prescription drugs.

And similar to the mission of the individuals sitting with me today, I continue to dedicate my career towards

efforts aimed at addressing our equally important public health role. That is to ensure that there is an adequate and uninterrupted supply of controlled prescription medications to meet the medical, scientific, and research needs of the U.S. It is that mission, embodied by changes to the CSA resulting from passage of the SUPPORT Act in 2018, where I hope to focus today's discussion. I am happy to be here with my Federal partners to explain the steps DEA is taking to ensure that patients in need of vital medicines have safe and ready access.

On the top of this list is DEA's full support to improve and expand access to important treatment drugs like buprenorphine and methadone. This includes next week's implementation of the MATE Act, as well as the repeal of the X waiver for prescribing buprenorphine. It includes our efforts to facilitate induction of new patients on buprenorphine, using telemedicine and ongoing efforts to improve access to MOUD in carceral settings.

We are also working to ensure Americans in underserved areas have access to health care. We are considering changes to regulations in response to the more than 38,000 comments

we received on 2 draft telemedicine rules published in March. And we will establish clear and simplified rules with guardrails for the prescribing of controlled substances.

We continue to work in close collaboration with the FDA, manufacturers, and distributors to understand the causes for a growing list of drug shortage reports from patients regarding amphetamine-based pharmaceutical products, primarily generic Adderall, used in the management of ADHD.

And finally, we have done tremendous work to ensure schedule I controlled substances, including marijuana, MDMA, and psilocybin are available to our 842 researchers from a growing list of domestic sources.

Thank you for the opportunity to be here today, and I look forward to your questions.

[The prepared statement of Strait follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. Thank you for your testimony.

The chair now recognizes Dr. Christopher Jones for your opening statement.

STATEMENT OF CHRISTOPHER JONES

*Dr. Jones. Thank you, Chair, Chair Guthrie, Ranking Member Eshoo, and distinguished members of the committee. Thank you for the opportunity to be here today to discuss the CDC's efforts authorized by the SUPPORT Act to address our nation's overdose crisis.

This crisis has profoundly impacted our nation. CDC's most recent data show that 300 Americans are dying each day from overdose, and many millions more struggle with substance use. The historic increases we have seen in overdose deaths in recent years are facilitated by a rapidly changing and highly lethal drug market saturated with illicitly-made fentanyl and the resurgence of stimulants like methamphetamine.

The ever-changing drug landscape continues to present emerging and novel threats to the health of our nation. And behind these statistics are individuals, families, and communities that have been deeply impacted. However, we remain resolute in our belief that we can alter the trajectory of this crisis. At CDC we are working urgently to

save lives today, while also building a strong foundation of prevention to protect future generations.

CDC prioritizes five strategies that align with the HHS overdose prevention strategy: monitoring, analyzing, and communicating trends; building state, tribal, local, and territorial capacity; supporting providers, health systems, payers, and employers; partnering with public safety and community organizations; raising public awareness; and reducing stigma.

CDC invests in communities across the country to the national program Overdose Data to Action, or OD2A, that supports the critical work being done by health departments in our country. This program is improving fatal and non-fatal overdose data collection, analysis, and dissemination, advancing prescription drug monitoring programs, and other health system innovations, and driving targeted prevention efforts tailored to individual community needs.

Building on knowledge gained from the OD2A program over the past four years, CDC will fund two new programs this fall. Overdose Data to Action in states will fund state health departments to continue expanding innovative data

efforts while implementing prevention activities to decrease fatal and non-fatal overdoses and related harms. And through a second program, OD2A local, CDC will provide direct funding to up to 40 city, county, and territorial health departments to directly advance their local overdose prevention efforts.

In addition, CDC continues to advance innovative partnerships through multiple public health and public safety collaborations, partners with health systems to improve upstream prescribing and pain care, enhance linkage to care and services, and reduce stigma among clinicians.

CDC also strengthens national laboratory capacity by developing tests and reference materials on synthetic opioids, stimulants, and other drug threats for clinical and public health labs.

We have also made great strides in improving the timeliness and completeness of drug overdose death certificate data working closely with vital records offices and medical examiners and coroners across the country. These activities are complemented by other work at CDC, focusing on specific at-risk populations. This includes efforts to prevent and respond to infections commonly associated with

illicit drug use like HIV and viral hepatitis; preventing prenatal substance use and related harms by improving data collection on neonatal abstinence syndrome; establishing a data network to examine outcomes associated with MOU receipt during pregnancy; and connecting mothers and babies with needed services.

Moving forward, flexibility to address emerging threats and new drug threats is paramount so CDC can quickly scale support to jurisdictions and help health departments and communities adapt strategies to meet their needs.

Finally, preventing substance use in the first place is a core component of CDC's work and the long-term solution to reversing the overdose crisis. Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood, such as witnessing or experiencing violence, growing up in a family with substance use or mental health challenges, or losing a parent to overdose. Research consistently shows that ACEs are strongly linked to future risk for substance use and addiction, mental health challenges, and suicide. And CDC is working to strengthen ACEs data collection and supporting efforts in communities to

prevent ACEs and promote positive childhood experiences. By addressing these root drivers, we have a real opportunity to get ahead of the mental health and substance use challenges facing our nation.

For far too long, the tragic consequences of substance use and overdose have devastated families and communities across our country. As a person in long-term recovery, I know firsthand the devastation and pain that addiction can inflict. But I have also experienced the transformative power of recovery. CDC is committed to continuing using data, science, innovation, and collaboration as part of a whole-of-government effort to save lives and bring it into our overdose crisis

Thank you for the opportunity to be here. I look forward to your questions.

[The prepared statement of Dr. Jones follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. I thank you for your testimony.

The chair now recognizes Mr. Coderre for five minutes for your opening statement.

STATEMENT OF TOM CODERRE

*Mr. Coderre. Thank you, Mr. Chairman and Ranking Member Eshoo, for inviting me to testify before you today. My name is Tom Coderre, and I serve as the acting deputy assistant secretary for mental health and substance abuse at the Substance Abuse and Mental Health Services Administration.

I would like to start today by sharing a short story with you. This story is about a man who came from a loving family and had many friends. He was deeply involved in his community, enjoyed politics and policy, and was elected to the state senate at 25 years old. By 30 he had risen in his career to become the executive director of a large non-profit agency. On the outside, everything about this man's life looked normal. Some would even say ideal.

However, on the inside he was tortured. So he turned first to alcohol, and then to other drugs to cope with the stress in his life. Under-estimating the power of these substances, and unaware of the neurological consequences, he became addicted and his life began to unravel. He started to

lose the things that were most important to him. When his family and friends tried to help, he resisted their help and he pushed them away. This caused him to lose them.

He lost his job and his position in the senate. His health deteriorated. He lost his apartment and became homeless. He lost his spirit. In the end, he lost everything, even his desire to live. This man's life, which at one time was so full of hope, became hopeless.

I know this story well because it is mine. Fortunately, I was able to get the help that I needed. And today I am a person in long-term recovery -- just look at my friend, Dr. Jones -- which, for me, means I haven't been able to use alcohol or drugs since May 15 of 2003. During these 20 years in recovery, my life has improved dramatically. Being in recovery has not only enabled me to create a better life for myself, but it has also enabled me to create a better life for my family and my entire community.

With help, people can and do recover from substance use disorders. I am here today not only representing SAMHSA, but I am one of the more than 20 million Americans who have resolved their issues with substances.

Unfortunately, too many people do not have stories as hopeful as mine. In January SAMHSA released the latest National Survey on Drug Use and Health, which estimates that 46.3 million people in this country had a substance use disorder. SAMHSA's charge is to ensure that every one of them can get evidence-based treatment to continue to support their success once they enter recovery, and to work to prevent others from starting down that dangerous path. That is why SAMHSA focuses on the full range of the care continuum: prevention, intervention, treatment, and recovery support.

My written testimony goes into more details than the time I have today, so I just want to comment briefly on two programs established or enhanced by the SUPPORT Act, the topic of today's hearing.

I am grateful to the Members of Congress who have led this critical effort, to the members of this committee for their support and their attention to this work today.

Among the many important programs authorizing the SUPPORT Act, the law's enhanced funding for first responder training for opioid overdose reversal drugs has provided

resources to rescue individuals at the brink of death by preventing opioid overdoses. This program provides resources for first responders and members of other key community sectors to administer FDA-approved emergency treatment for known or suspected opioid overdose.

During the program's recent grant period, grantees distributed more than 340,000 Naloxone kits with grant funds, and administered Naloxone more than 157,000 times. By the end of 2022, grantees had also conducted over 41,000 trainings and trained more than 188,000 individuals on how to respond to opioid-related incidents.

At the other end of the continuum, the Treatment Recovery Workforce Support Program established by the SUPPORT Act provides the resources so that people in recovery can find stability, live independently, and participate in the workforce. Grantees provide treatment or recovery services for individuals with substance use disorders and partner with one or more local or state entities to provide a broad range of support services.

In fiscal year 2022, the modest program helped over 1,600 people stay in recovery, attend school and/or work, and

achieve permanent residence in their communities. These crucial SAMHSA programs, along with many others in the SUPPORT Act, are up for reauthorization. These programs are making a difference in people's lives in states and communities across our nation.

So thank you for the opportunity to appear before you today and for your dedication to this issue.

[The prepared statement of Mr. Coderre follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. Thank you for your testimony.

Ms. Espinosa, you are recognized for five minutes for your opening statement.

STATEMENT OF DIANA ESPINOSA

*Ms. Espinosa. Chairman Guthrie, Ranking Member Eshoo, and members of the subcommittee, thank you for the opportunity to discuss the Health Resources and Services Administration's efforts to expand access to substance use disorder treatment and prevention services, and to grow the behavioral health workforce.

My name is Diana Espinosa, and I serve as the principal deputy administrator of HRSA, the agency that supports delivering health care in the nation's highest-need communities, building the health workforce, improving maternal and child health, and meeting the health care needs of rural America.

I would like to begin by thanking the members of the subcommittee. With your help we have made meaningful gains in expanding behavioral health services and training more providers. Through the SUPPORT Act HRSA launched the Substance Use Disorder, Treatment, and Recovery, or STAR, Loan Repayment Program to recruit and retain clinicians and paraprofessionals who provide direct treatment and recovery

support for patients. The program repays the educational loans of providers who deliver six years of full-time service in communities with the highest overdose rates in the country.

Today, across the United States, 445 clinicians and community health workers are providing direct treatment and recovery support to patients through this program. And by the end of the fiscal year, that number will increase to over 600 providers.

The SUPPORT Act also provided authority for other critical behavioral health workforce programs, which are training providers in community-based settings. During the recent academic year these programs trained over 7,800 behavioral health providers.

HRSA's National Health Service Corps also plays an important role in combating the overdose epidemic by growing and retaining a skilled workforce of behavioral health professionals, and increasing access to services in rural and underserved communities. Currently, more than 9,600 mental health and substance use disorder providers are practicing in the highest need communities, thanks to the National Health

Service Corps.

Mandatory funding for the National Health Service Corps expires at the end of this fiscal year. The President's budget seeks to sustain the record level of clinicians in service, and provide a three-year mandatory investment in the program.

HRSA created the Rural Communities Opioid Response Program, the only targeted program focused specifically on addressing substance use disorder in rural communities. HRSA has invested over $500 million across more than 1,800 rural counties in nearly every state via RCOR, and grantees have provided direct services to nearly 4 million people living in these rural counties.

The Health Center Program is also a tremendous resource for increasing access to behavioral health services, given its broad footprint and valuable role as a trusted provider in communities across the country. Targeted investments have helped health centers expand their capacity to deliver behavioral health services, including increasing the number of patients receiving mental health and substance use disorder services.

Still today, health centers are only meeting about 27 percent of estimated demand for mental health services, and approximately 6 percent of estimated demand for substance use disorder services among their patients. Mandatory funding for the Health Center Program expires at the end of this fiscal year, and the President's budget proposes a new $700 million investment to expand behavioral health services in health centers, along with a requirement that they provide mental health and substance use disorder services.

HRSA continues to expand access to substance use disorder services and grow the behavioral health workforce through its SUPPORT Act programs and others.

I look forward to your questions about our programs. Thank you.

[The prepared statement of Ms. Espinosa follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for your testimony. The Chair now recognizes Mr. Blum.

You have five minutes for your opening statement.

STATEMENT OF JONATHAN BLUM

*Mr. Blum. Thank you, Mr. Chair, for the opportunity for CMS to present today.

CMS deeply thanks this committee for authorizing the SUPPORT Act. This law has provided new tools to CMS to address the devastating toll substance use has taken on those covered by CMS programs.

This toll has only worsened during the past five years. While progress has been made, we agree that more must be done.

CMS works hand in hand with the other agencies here to build system capacity, connect more people to care, and integrate behavioral health services with primary care and other social support services. For CMS, we have built a comprehensive plan that coordinates work throughout the agency and supports broader department and presidential strategies.

As the largest payer of care here in our country, CMS works to ensure that our payment, coverage, and quality programs promote person and patient-centric behavioral health

care.

As stated, the SUPPORT Act provided CMS new tools and authorities to provide better care for patients. Medicare now provides for treatment in more care settings. We have launched new payment models to test value-based payment concepts. We have worked closely with states to help their efforts to expand Medicaid options that provide broader treatment options. We now require CHIP programs to expand coverage for services. We have provided planning grants to states to bolster their care delivery systems, and we have expanded data monitoring for prescribers.

So the SUPPORT Act only has five years -- it is only five years old. We are seeing positive change to our programs. But given the demand for services, we must continue to find new ways to improve our policies. The President's budget proposes many policies to expand coverage and access to behavioral health treatments. These include stronger mental health parity provisions for the states, requiring Medicare and private health insurance plans to cover three behavioral health visits with no cost sharing, converting successful demonstration programs to permanent

programs.

I have personally traveled throughout the country to many states, and have seen firsthand the challenges that our care systems now face. Health care providers and other stakeholders tell us how much greater demand there is for behavioral health care services today in both urban and rural settings. Our programs are stronger today, thanks to the SUPPORT Act, but we know that more can be done and more must be done.

CMS stands ready to support this committee's work. Thank you for the opportunity again. I look forward to your questions.

[The prepared statement of Mr. Blum follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. I appreciate your testimony. That concludes all of our witnesses' testimony. And we will move to questions, and I will begin the questioning by recognizing myself for five minutes for questions.

So, Mr. Coderre, we are here today to examine what has worked and what hasn't worked over the past several years. We have also spent billions of dollars on treatment and recovery programs. According to a December 2021 Government Accountability Office report, SAMHSA spent 2.8 billion in state opioid response grants, and there were over 2.2 billion in unspent funds during fiscal year 2020.

I understand fiscal year 2020 is a difficult year to benchmark because of all that was going on with COVID, and it could have impacted funds. However, SAMHSA's data shows that the base award for SOAR grants was 1.4 billion in 2020, and the draw-down was 1.421 billion.

Why is there a discrepancy in the GAO's reporting and the SAMHSA's website?

And for drawdowns, does that mean states spent all those funds, or does that only mean they took the funding?

And how can we be more targeted with our funding?

*Mr. Coderre. Thanks so much for that question, Mr. Chairman.

The State Opioid Response Grant Program has been incredibly important to states and local communities over the years, and we at SAMHSA have worked very closely with states about how to spend those resources effectively.

What we have heard from states is that they have had difficulty spending those resources in the amount of time that the grant period allows for. So we are working with states, and we would be happy to work with the committee to address any of those drawdown questions that you have.

*Mr. Guthrie. Okay. Is there opportunities to include other things such as alcohol abuse?

I was on jury duty, I did my civic duty about three years ago, and grand jury about -- of 20 cases a day that came before us. It was amazing to me how many were alcohol-related.

*Mr. Coderre. Certainly, you know, alcohol becomes -- it is a major issue in this country. Alcohol use disorder is impacting millions of Americans.

So we at SAMHSA are working as closely with states and

local communities as possible to make programing available to them. The SOAR program itself is specific to opioids and stimulant use disorder. However, we would be happy to work with the committee on any of those, expanding that program in any way that we can.

*Mr. Guthrie. Okay. Also, Mr. Coderre, the Comprehensive Opioid Recovery Centers was an issue I championed. We need to have access to all types of treatment and wrap-around services. Could you talk about that program, and what has been successful?

*Mr. Coderre. Certainly, Mr. Chairman. That program --

*Mr. Guthrie. And improvements. What was successful in any improvements? So that is what we are here to -- what can we --

*Mr. Coderre. Sure. Well, as you said, the Comprehensive Opioid Recovery Center Program provides grants to non-profit SUD treatment organizations to operate those comprehensive centers and provide that full spectrum of treatment and recovery support for opioid use disorders.

Grantees are required to provide outreach and the full continuum of treatment services, including medications for

opioid use disorder, counseling, treatment for mental disorders, testing for infectious diseases. Very, very comprehensive, as you pointed out.

And so, with that appropriation of $6 million, SAMHSA funded 5 of these centers in fiscal year 2022. The grantees utilized the funding to expand access to comprehensive service in a variety of ways.

*Mr. Guthrie. Would you view that as successful?

I am going to get to a couple other questions. Would you view that as successful?

*Mr. Coderre. Yes, we view that program as very successful.

*Mr. Guthrie. And what do you think needs to be improved? Is there --

*Mr. Coderre. Improvements for it? Happy -- I don't have any suggestions for improvements today, Mr. Chairman, but I would be happy to work with you and your staff.

*Mr. Guthrie. Absolutely. We want to make sure we get this right.

*Mr. Coderre. Absolutely.

*Mr. Guthrie. And we -- after five years in all of your

areas you talk about, what things can we do better? That is what we want to move forward.

So Mr. Strait, having you here today, I can't help but talk about fentanyl analogs. And how simple is it to produce a fentanyl analog?

And how many fentanyl analogs is DEA aware that you guys believe are out there?

*Mr. Strait. Yes, thank you for the question.

At present, since this threat has kind of really emerged, we have scheduled a total of 36 individual analogs. Now, that would be after we have developed enough evidence to represent that they represent a risk to the public. That is when we would then use our emergency scheduling authority to take permanent action to control that substance. But there are hundreds of substances out there, and the ability to actually make an analog is slightly easy in that all you have to do is make a slight modification to any portion of the --

*Mr. Guthrie. So it really could almost be infinite, the combinations out there.

*Mr. Strait. There has been --

*Mr. Guthrie. Could be.

*Mr. Strait. -- questions about whether there is an infinite number, and I think that is theoretical. I think it is more likely that --

*Mr. Guthrie. Have you seen fewer analogs since the temporary scheduling took place?

And do you think permanent scheduling would -- should be continued, the temporary should be permanent?

*Mr. Strait. We absolutely believe the temporary scheduling should be permanent, and we have seen fentanyl analogs decrease in terms of their prevalence.

*Mr. Guthrie. Okay, thank you. My time is expired. Thank you for your answers. And I now recognize the ranking member for five minutes for her questions.

*Ms. Eshoo. Thank you, Mr. Chairman, and thank you to each of the witnesses for your testimony, which is your work.

Mr. Coderre, you are a source of inspiration to me, I think to everyone in this room, that you would choose to tell a story, and that it is your story. So thank you. Thank you.

*Mr. Coderre. Thank you.

*Ms. Eshoo. And thank God and everyone that helped you.

To Mr. Blum, over 50 million Americans live with chronic pain, and this drives many individuals, you know, to seek relief through opioids. The SUPPORT Act section 6086, the Dr. Todd Graham Pain Management Study, required CMS to study and report on non-opioid therapeutic services for pain management for Medicare beneficiaries. The study was done in 2019.

What is CMS doing to -- in the meantime -- to improve access to non-opioid treatment options to reduce pain?

CMS hasn't issued the report, so this is a while. This is -- how many years -- 2019 is, what, 4 years ago. So where is the report, and what is CMS doing in the meantime?

*Mr. Blum. Thank you for the question.

We believe that one of the greatest challenges that our CMS programs have is not having sufficient access to those that treat chronic pain. So we need to do more to expand CMS --

*Ms. Eshoo. Yes, well, that is a given. That is a given. Everyone, I think, would agree to that. But where is the report? When do you think it is going to be issued? And in the absence of it, what has been -- what has CMS --

*Mr. Blum. Sure.

*Ms. Eshoo. What has CMS been doing?

*Mr. Blum. I will get back to your office with a status report for the status -- for the report. But in the meantime, CMS works tirelessly to expand physician networks to ensure that we have a better coverage for pain management services.

*Ms. Eshoo. Something is really wrong that a report is -- it seems, from where I sit, that this is just forgotten. So we need to -- the committee needs to get that information.

To CDC and DEA, in the past year deaths and severe medical complications have soared due to Xylazine. That is a drug that is -- currently has veterinary and agricultural uses being mixed into street drugs. It is just astounding to me what is taking place.

And I would also like to know from both Mr. Jones and Mr. Strait, do you have the data capabilities to track emerging drug threats like Xylazine?

And do you know where there are hotspots?

And can you identify the trends to prevent these overdoses?

I mean, people are using. And so it seems as if, you know, there is constantly a new -- something that is introduced. People are just using. They don't -- in terms of this scheduling business, I don't think they check out to see what is scheduled. They are using drugs, and those that are peddling them are constantly introducing all these others.

So what is your capacity for, you know, for -- as I said, do you have the data capabilities to track these drug threats?

*Dr. Jones. Thanks for the question. At CDC we put out our first notes from the field on Xylazine in September of 2021. So almost two years ago, we started sounding the alarm that we were seeing Xylazine pop up in certain communities, and that was consistent with data from DEA. And those data come from our state unintentional drug overdose reporting system, which is a system that we support --

*Ms. Eshoo. So you do have the capability?

*Dr. Jones. So we have -- yes. That system captures very granular toxicology information on deaths, and states have access to those data through our Overdose Data to Action

program. We use that to raise awareness.

We recently also published through checking of drug paraphernalia syringes in Maryland, sort of a novel approach to trying to identify emerging threats, we also saw that Xylazine was very common in that area, as well -- again, consistent with what information comes from DEA.

So we are continuing to try to raise awareness of those data systems that do exist, but also continuing to look for additional opportunities to get ahead of new emerging threats.

*Ms. Eshoo. Thank you. My time is expired.

Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair now recognizes the chair of the full committee, Chair Rodgers, for five minutes for questions.

*The Chair. CBO recently found that states that lifted the IMD exclusion, whether through 1115 waiver or through the SUPPORT Act's state plan option, saw reductions in emergency room visits for overdoses. Nearly 40 states have chosen to lift the IMD exclusion.

As we work to reauthorize the SUPPORT Act state plan

option, a key goal is ensuring that we increase uptake of these options and reduce state burden. So, Mr. Blum, how long does it take to approve an 1115 waiver from the start of the state's process to the final CMS approval compared to a state plan option to get approved in, and would you speak to the difference in how long it takes?

*Mr. Blum. For states, CMS works carefully to approve waivers. Those timelines can vary. They can be dependent on the complexity to the waiver. So there is no set rule of thumb that we can provide that would say this is how long it takes to approve a state waiver. They have to go through notice requirements, they have to go through public requirements. But in general, that -- it takes longer for a state waiver than a state plan.

*The Chair. Can you give us a sense -- is it months or years?

*Mr. Blum. I would say months.

*The Chair. Months? The value of lifting the IMD exclusion is clear. Now is the perfect chance to find a way to reduce state burdens and find a more permanent solution to lifting the IMD exclusion.

There has been a lot of discussion about how to lower overdose rates and set individuals up for success upon leaving jail or prison. Mr. Blum, the SUPPORT Act allows states to suspend Medicaid coverage when an individual is incarcerated, rather than terminate their coverage, and the goal being that suspending coverage would mean that an individual can more easily resume Medicaid coverage upon their release from prison.

Would you speak to the technical assistance that CMS provided to states to help clarify their ability to suspend coverage for individuals, and do you see states doing this?

*Mr. Blum. So CMS today is very excited to work with states to help them build programs that ensure better continuity of care. We recognize that those that are leaving prison often times have tremendous breaks to their care, to their coverage. So today CMS is eager to work with states to help to improve those programs.

*The Chair. How many states are doing this?

*Mr. Blum. I will have to get back to you with that precise number, but it is relatively small.

*The Chair. Okay. Thank you.

Mr. Strait, in your written testimony it discusses the work DEA has done with Bureau of Prisons to enable them to provide medication-assisted treatment. Have you seen more of this care provided, especially pre-release?

*Mr. Strait. Well, that action culminated in March of 2023, so I would probably say it is a little early to know the consequences of it, but we do think that was an important step. We granted NTP, or opioid treatment program designation, to all 97 BOP facilities, greatly impacting access there.

*The Chair. Okay, thank you. I would like to quickly flag my concerns with CMS's 1115 waivers to allow for Medicaid to pay for care for inmates in jails and prisons. I questioned the authority of the agency to do this. And these new waivers appear to be far from budget neutral, a key 1115 waiver requirement. The section of support you cite in your testimony as rationale for this only required innovative strategies, and did not give authority to waive budget neutrality. And I hope that we can find a way forward on these policies that are ultimately authorized and actually authorized by Congress.

Mr. Coderre, your written testimony indicates that over 85 percent of SAMHSA's prevention resources are dedicated to youth-focused primary prevention activities. Mr. Jones's written testimony includes a tragic statistic: drug overdose deaths or, more likely, poisonings among younger-aged people, 10 to 19, have risen 65 percent from July 2019 to December 2021, even though overall youth illicit substance use declined. How do you measure the success of these primary intervention programs?

*Mr. Coderre. Thanks so much for your question, Madam Chair.

SAMHSA's prevention programs are vital to providing mental health and substance use services, and we are working closely with our partners in the state and local communities to provide resources to enact these programs. I would be happy to work with you and your staff to get you some of the data from those programs about the measures of success. We have lots of those that we collect through our data systems, and we can -- we are happy to provide those to you.

*The Chair. Well, we are moving in the wrong direction, so we need to look at what is actually going to get results

is my point.

*Mr. Coderre. Thank you.

*The Chair. Okay, thank you.

I yield back.

*Mr. Guthrie. Thank you. The chair yields back. The chair now recognizes the ranking member, Mr. Pallone, for five minutes for --

*Mr. Pallone. Thank you, Mr. Chairman. My questions are all of Mr. Blum, and mainly about the IMD program.

I want to make sure that, in our rush to respond to the opioid epidemic, we do not inadvertently create different problems as the unintended consequences of our actions. And I am particularly concerned that further weakening the Institution for Mental Disease, or IMD exclusion, in Medicaid could lead to an increase in institutionalization that would further isolate individuals struggling with substance use disorders.

So Mr. Blum, five years ago the SUPPORT Act authorized a temporary Medicaid state plan amendment that created an exception to the IMD exclusion for individuals with substance use disorder. In the five years since, how many states have

adopted this option?

*Mr. Blum. Two states, Congressman.

*Mr. Pallone. Two? Only two? I mean, it sounds like this has not been a very popular policy on the ground.

So I wanted to address the fact that states already have options to receive Federal Medicaid funds for certain states in an IMD. They can use the longstanding authority in Medicaid-managed care known as in lieu of services to cover short-term stays in IMDs of up to 15 days each month, and states can also use 1-1-1-5 -- pronounced 11, 15 -- waivers to cover longer stays in IMDs, as long as the state average length of stay is less than 30 days.

So again, Mr. Blum, how many states currently have these 1115 waivers to cover IMD stays for substance use disorder?

*Mr. Blum. Thirty-four states, plus D.C.

*Mr. Pallone. Okay. So, in other words, the overwhelming majority of states have adopted the 1115 waivers to cover IMD stays for beneficiaries with substance use disorder, and only 2 states have adopted the expiring state plan option. Is that what you have basically said?

*Mr. Blum. Yes, sir, that is correct.

*Mr. Pallone. All right. Well, thank you.

I mean, again, it sounds to me like, for states that do not want to cover IMD stays -- that do want to cover the IMD stays, I should say -- the 115 -- or the 1115 waivers are a much more popular approach than the state plan option that the Republicans are attempting to extend. And I think we would be far better off allowing states to cover IMD stays with 1115 waivers, which CMS does not need any additional statutory authority to approve, rather than doubling down on the -- what I consider a failed approach of the state plan amendment.

Now, again, I mean, I am saying this because I wasn't -- you know, I am always very wary of IMDs and institutionalization. And so, you know, I think we should just continue with the 1115s, rather than trying to expand, you know, this state amendment that allows for expanded IMD.

But I also wanted to ask you one more question unrelated to IMDs. We have heard from a number -- or I should say I have heard from a number of advocates that, rather than investing more Federal dollars towards institutional care, we should instead focus on supporting treatment options that

allow individuals to stay in the community. Obviously, that is always my preference, and I think most members feel that way.

So, Mr. Blum, can you talk about the value of home and community-based care for individuals in recovery?

*Mr. Blum. Thank you for the question. One of the principles that we feel very strongly about is that when helping to support states to design their programs, that those programs should provide the full spectrum to care options that best serve the patient, given where they want to receive services.

We know that many patients want to receive services in non-hospital settings. We have recently worked with states to expand services, for example, in schools that really provide services where people are. So our core principle is to work with states carefully to ensure that services are provided with the full spectrum that ensure that patients can receive services where they are most comfortable.

*Mr. Pallone. No, I appreciate that. And again, you know, I know it is difficult because a lot of times when you talk about community-based care, there are those in the

community that -- you know, a not-in-my-back-yard type of thing, right?

But I just think that when we have resources -- and they are always limited -- we are better putting them towards treatment options that support community integration and keep people in the community, rather than institutionalization. So that is my view, and I appreciate your input, Mr. Blum.

Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Burgess for five minutes for questions.

Dr. Burgess.

*Mr. Burgess. Thank you, Chairman.

Dr. Jones, from the perspective of the CDC, does this country have a problem with homelessness?

*Dr. Jones. Certainly, there are many communities that are struggling with people experiencing homelessness, yes.

*Mr. Burgess. So let me just ask you a question. Is one of the root causes -- people like to talk about root causes -- is one of the root causes of homelessness untreated mental disease and untreated addiction?

*Dr. Jones. We see certainly higher prevalence rates of mental health and substance use disorders among people experiencing --

*Mr. Burgess. So, okay, let me just -- let me boil it down for you: What we are doing may not be working. And so we could do a lot more of it, and hurt people in the -- as a consequence.

But, Mr. Blum, your comments and your back-and-forth with the ranking member of the full committee, it seems logical that you would try to help those people who have untreated mental disease and who want help with addiction, who are not able to receive it, and thereby not be subject to the degree of homelessness and misery that they currently are. Is that not a fair statement?

*Mr. Blum. We believe strongly that we need to expand services and do so in a way that provides the full spectrum of care services.

*Mr. Burgess. So I have a number of things, Mr. Chairman, that I am going to ask inclusion in the record, and one of them is a letter from the Schizophrenia and Psychosis Action Alliance. And within their letter they talk about the

IMD exclusion is a manufactured and artificial scarcity of public and private psychiatric hospital beds resulting in sky-high utilization of hospital emergency departments among persons with severe mental illnesses.

In fact, the American College of Emergency Physicians reports a persistent boarding crisis in hospital emergency rooms with individuals in psychiatric crisis. Is that a fair statement from the Schizophrenia and Psychosis Association?

*Mr. Blum. I haven't seen the letter, Congressman, but I can tell you that, through personal travels, that we hear very similar statements.

*Mr. Burgess. Correct. Boarding in our emergency rooms is literally at a crisis level. And one of the reasons for that is trying to get a bed for someone who requires hospitalization. And I just submit that the IMD exclusion is making this -- well, certainly not helping that problem. And that is why it is important for us to be evaluating it.

So just in general, Mr. Blum, the United States, we have got a significant mental health and substance abuse crisis, increasingly difficult to manage.

Mr. Strait, I agree with you. The border issue is --

man, oh, man, that is front and center. And if you all take any information back to your counterparts in the Administration, that is one that has to be fixed. But limited treatment options for substance abuse and mental health and barriers to -- access to comprehensive care, especially for Medicaid beneficiaries, that plays a role.

CBO, I do have a CBO estimate on this. It is high. And Mr. Chairman, I would like to insert that for the record, as well.

But the cost of doing nothing is staggering. So yes, we can look at the CBO, look at the CBO score and say, oh, that is so big we really can't do anything about it, but we have to do something about it. It is our obligation to do something about it.

So, Mr. Blum, staying with you, how have states applied the 1115 waiver to lift the IMD exclusion to improve access to care for substance abuse disorders?

*Mr. Blum. There are 34 states that have moved forward with that option.

*Mr. Burgess. Yes. And just as an aside, it was extremely difficult to get the 1115 waiver extended in the

State of Texas when the Administration changed from the Trump Administration to the Biden Administration. The Trump Administration gave a 10-year extension of the 1115 waiver for the State of Texas. The Biden Administration came in and four months later said, "No, we are not going to extend. We have made a mistake. It is not going to be extended at all.''

It took a full year, a full year, to get that extension of the 1115 waiver. And that is why it is difficult using the 1115 waiver, because it is not necessarily assured that it is going to continue, for political reasons, from one administration to the next.

Mr. Chairman, I have got a number of questions that I am going to submit for the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Burgess. And I do have the CBO score and various letters that I would also like to submit for the record, without objection.

*Mr. Guthrie. I think we are going to do an action at the end of all the letters on the record, so we will make sure everybody has a chance to review those. But yes, those -- we will put those on our list for the end of the -- unless you have any -- you would rather review.

No objection? If there is no objection, so they are so ordered, yes.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Now the chair now -- the gentleman yields back. The chair recognizes Ms. Kuster for five minutes for questions.

*Ms. Kuster. Thank you, Mr. Chairman, and thank you to our witnesses for your testimony. And I apologize when we are scheduled for two hearings at once.

Your leadership highlights the importance of our Federal agencies working together to address the addiction crisis. As the founder and co-chair of the bipartisan Mental Health and Substance Use Disorder Task Force here in Congress, I am glad we are dedicating time to discuss the issues posed by the co-occurring mental health and substance use disorder illnesses.

We must do more to respond to these challenges. We all have a role to play in reducing the stigma around mental health and addiction. CDC data shows that around 300 Americans die every day from drug overdoses, 300 mothers, fathers, sisters, brothers. We know the number of people suffering from mental health challenges is even higher than that. And this hearing comes at a critical time for this committee.

I would like to highlight some of the opportunities we have to improve the SUPPORT Act during reauthorization. I am excited that today's hearing includes two important bills that will change the outdated Medicaid inmate exclusion policy: the Medicaid Reentry Act, from my colleague, Representative Paul Tonko; and the Due Process Continuity of Care Act from my colleague, Representative David Trone. Letting people who are incarcerated keep their Medicaid coverage will support healthy communities, and ultimately save state and taxpayer dollars.

My bill, the Humane Correctional Health Care Act, would actually end the Medicaid exclusion -- inmate exclusion policy altogether, and I totally support the efforts of my colleagues to chip away at this harmful policy.

I am also glad that today's hearing includes my bill with Representative Buddy Carter, the Studying Suboxone Act, which will increase accessibility to this important medication that helps people with opioid use disorder.

The Star LRP reauthorization bill is an important tool that we must support to expand our behavioral health workforce.

However, there are bills that we are not discussing today that should be a part of this conversation. My bill with Representative Lisa Blunt Rochester, Stop Fentanyl Overdoses, is a comprehensive, bipartisan approach to reducing the harms of the opioid crisis, leveraging many of the programs that have been discussed today.

Additionally, expanding access to methadone for opioid use disorder beyond the restrictive setting of opioid treatment programs will enable more people to seek this treatment. And I support Representative Norcross's bill.

I also worked with several of my E&C colleagues to reach out to both DEA and SAMHSA to maintain telehealth prescribing for buprenorphine, allowing for continued access to a critical medication for people with opioid use disorder.

Mr. Blum, in your testimony you highlight research that the expanded availability of telehealth services and medication during the pandemic was associated with fewer fatal drug overdoses for people on Medicare. Can you explain how telehealth is specifically important in the prescribing of medications for opioid use disorder?

*Mr. Blum. Thank you for the question. We saw

tremendous growth in telehealth services throughout the country during the pandemic, particularly for behavioral health services. And we feel that we believe that maintaining access to these services is crucially important for many patients, that it helps to promote access.

There are still many questions that we have to better understand for what is the right payment level, for what is the right processes for us to ensure broad access to those services. But in general, we are very supportive to continuation for telehealth services for these services.

*Ms. Kuster. Great. Thank you very much. I look forward to hearing more from both DEA and SAMHSA before the November expiration of this rule.

Today's hearing demonstrates that we must take an all-of-government approach to addressing the mental health and substance use disorder crisis that is affecting, literally, every single community in our country.

I thank my colleagues for committing to a bipartisan reauthorization that will meet the needs of our constituents, and with that I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back.

The chair now recognizes Mr. Griffith for five minutes for questions.

*Mr. Griffith. Thank you very much, Mr. Chair.

Dr. Jones, I helped lead section 7161 of the SUPPORT Act in 2018 that would support and improve prescription drug monitoring programs. My thought was the money authorized for that was to start up the programs and increase collaboration across state lines. The bill that reauthorizes this section is in front of us today -- authorizes an increase in funding.

So can you elaborate -- so one, can you elaborate how the money in this program is being spent between agencies and states?

And two, if the systems are already in place, we already did the start-up from the last bill, explain to us why there is a need for an increase in the funding.

*Dr. Jones. Thank you very much for the question. And through our Overdose Data to Action program, that is how we provide funding to states to support Prescription Drug Monitoring Program work. The Bureau of Justice Assistance, who is not here today, is the other Federal funder of PDMPs.

In our work, you are correct, the systems, you know,

four or five years ago -- or still getting started in some states -- are moving from paper-based systems to electronic-based systems. So we have made great progress over the last several years in having electronic systems that exist, having regular and very current reporting from pharmacies to the PDMP, and improving interstate data sharing across.

I think where there continue to be opportunities is to integrate the PDMP data into electronic health records, clinical decision support. It is an important piece of information for clinicians to have, and we don't want them to have to go to a separate system that disrupts their workflow. So I think there is opportunity there, and better integration in clinical workflow.

And then from a data analysis perspective, it is also an important tool for health departments to understand what are overall prescribing trends in a state, how are things changing, where might they target educational resources.

So states have used our funding to not only have staff to be able to analyze those data more regularly, but then also to have academic detailers go out and say, here is an area where we are seeing some troubling trends. What might

be driving this? Can we help improve knowledge about appropriate prescribing of opioids or other pain management options? Or are we seeing a place where we might want to expand access to buprenorphine? Because there is a desert for access to MOUD.

*Mr. Griffith. And I appreciate that. And I am carrying the bill again, but I wanted to make sure on the funding side that I had a good defense for it. And you have presented that. Thank you.

Mr. Strait, we were just talking about buprenorphine. With DEA's proposed rule on March 1, 2023, that will ease in-person requirements to be prescribed the controlled substance -- a controlled substance via telemedicine. And I am for telemedicine.

That being said, in some parts of my district it is being reported that buprenorphine, Suboxone, is being used as a street drug, that they are taking some and not taking some. So does the DEA track the prescription patterns or prescribing patterns on buprenorphine so we can see if expanding the number of patients any one doctor can have, and having telemedicine -- are we going to be prepared to keep an

eye on that to make sure this doesn't become a problem in and of itself?

*Mr. Strait. Thank you for that question. It is a great question.

And what I would tell you is that the best experience we have is what happened during COVID, when telemedicine flexibilities existed. And what I will say as a general matter is we did not see a, you know, an increase in diversion or misuse of buprenorphine.

I think the other piece is knowing that it is widely dispensed in combination -- as Suboxone, when it is in combination with naloxone, tremendously helps toward that end of ensuring that it is not going to be misused.

*Mr. Griffith. So what you are telling me is you are, in fact, tracking --

*Mr. Strait. Absolutely.

*Mr. Griffith. -- it. Okay, good. And in regard to the three-day rule -- and you amend the three-day rule for dispensing medication for opioid use disorder -- do you plan to have a monitoring system in place for that, as well?

*Mr. Strait. I am sorry. The three-day rule?

*Mr. Griffith. Yes. There is going to be -- apparently, the Department of Justice is releasing an amendment to the three-day rule for dispensing so that you can get a longer prescription.

*Mr. Strait. Yes.

*Mr. Griffith. Do you plan to monitor that for abuse, as well?

*Mr. Strait. Absolutely. And in fact, we have been granting exception letters in all 50 states to mostly hospitals. That has been going on for about the last year-and-a-half, as well, so that they can already -- during the pendency of our rulemaking, they can already do --

*Mr. Griffith. All right.

*Mr. Strait. -- a three-day.

*Mr. Griffith. And Dr. Jones, back to you, and I am running out of time. Can you explain briefly how the CDC's high resolution libraries function, and what research is being done into fentanyl analogs on your end?

*Dr. Jones. Yes, this is an active area for our National Center for Environmental Health, where they have really been leaders in developing new testing methods, as

well as sharing reference materials to public health and clinical labs.

So we have expanded beyond fentanyl, fentanyl analogs to synthetic stimulants, benzodiazepines, cannabinoids. We have over 300 in the high reference lab at this point.

*Mr. Griffith. All right. I would love longer answer, but my time is up and I must yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Cardenas for five minutes for questions.

*Mr. Cardenas. Thank you very much, Chairman Guthrie, and also Ranking Member Eshoo, for holding this hearing at this very critical time in our country. As we navigate a worsening substance use disorder crisis in this country, it is critical we come together to fund a Federal response that matches the severity of this emergency.

I am especially grateful to see the bill I am leading with Rep. John James. It has been noticed. Thank you so much. The Road to Recover [sic] Act will provide necessary resources to ensure the National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support

can assist individuals in need.

My first question is to Mr. Coderre.

Can you explain why the center is a helpful resource for community organizations and peer support networks, and why is peer support so critical to addressing those struggling with substance use disorder?

*Mr. Coderre. Well, thank you so much for that question, Congressman.

For me personally, peer support was essential for my recovery. Peer support taught me that I was not alone. Peer support taught me that treatment is effective, that people do recover. And so peer support workers are folks who have been successful in the recovery process, and are able to help others who are in similar situations through understanding, respect, mutual empowerment. And the workers help people become and stay engaged in their recovery process.

So the peer support services definitely can effectively expand the reach of treatment beyond that clinical setting that you referred to into everyday environment of those who are seeking sustained recovery.

*Mr. Cardenas. Thank you very much.

I also want to take a moment to discuss institutions for mental health disease exclusion, also known as IMD exclusion. Medicaid's IMD exclusion limits Federal Medicaid dollars to states for inpatient mental health services at facilities with no more than 16 beds. And by the way, I am still trying to figure out how we came up with the number 16. It is mind boggling.

Unfortunately, while the intent of the restriction was good, it has reduced the number of options for people who need certain levels of mental health care. With fewer care alternatives, more and more individuals end up in jail rather than getting the mental health services they need. In fact, half of the individuals in our jails across America today have been diagnosed with some kind of mental illness, as compared to about one fifth of the broader U.S. population.

Now, I want to be clear. I am not saying that relaxing some of those IMD restrictions should come at the expense of community-based services, and I certainly think we need to take a measured approach with safeguards in place. In fact, without guardrails I would be hesitant to repeal existing restrictions.

That being said, we are trying to address a massive mental health crisis, and we need to have a full set of care options. There are some individuals who are struggling with substance use disorder or other mental health issues who may need inpatient care. I am worried that by maintaining a broad exclusion, we are leaving out most middle-income and low-income families across our country that need access to quality care and necessary care.

Mr. Blum, I have heard from advocates who have concerns about the treatment patients receive in IMD settings. It is because of these conversations that I have been thinking through ways to promote the highest quality care and ensure accountability. One idea that comes to mind is creating certain standards of care that must be met for reimbursement. Would this be something CMS would be interested in working with us on?

And if so, what types of considerations should we be sure to keep in mind?

*Mr. Blum. I am happy to work with you, Congressman, that question. Today CMS maintains a robust criteria for all care settings, be it behavioral health or just general health

care services. We are happy to work with you to find ways to define services that are safe and high quality.

*Mr. Cardenas. Okay. Why is it important to ensure robust funding for community-based services for people dealing with mental health issues?

*Mr. Blum. What we learned from states, working with states, working with care systems -- that patients prefer care in different settings. And so we believe very strongly that, to build the strongest possible systems, that patients need to receive services that will best serve their needs. And so that is one important principle that CMS works to maintain throughout any conversation with the state.

*Mr. Cardenas. Is the emergency room a good place for somebody in a mental health crisis situation to be getting care?

*Mr. Blum. What we hear from clinicians is those settings tend to be chaotic. They tend to be noisy. They tend to be not the best care setting for patients.

*Mr. Cardenas. Well, that is where too much care is being handled, and we need to make sure we have the infrastructure to do otherwise. So thank you very much, I

appreciate it very much.

Mr. Chairman, my time is expired. I yield back.

*Mr. Bucshon. [Presiding] The gentleman yields back. I now recognize myself for five minutes.

Never mind. Mr. Latta.

[Laughter.]

*Mr. Bucshon. Mr. Latta, I recognize Mr. Latta for five minutes for his line of questioning.

*Mr. Latta. Well, I thank the chairman. And also, I appreciate the witnesses being here today.

It probably was announced a little bit earlier we have two hearings running today, and I am chairing the one downstairs right now. But we really appreciate your testimony today, and this is really an important hearing.

The United States has continued to fight an endless battle against the faceless enemy that knows no boundaries, and that enemy is the decades-long fight against substance abuse and addiction.

I want to start by saying addiction can happen to anyone.

I am saddened, after all the great work this committee

has accomplished at fighting addiction, we are still having these discussions. However, I am optimistic that, with improvements that are offered today in the SUPPORT Act reauthorization, we will have a -- be better positioned to provide access to care resources to those suffering and save lives.

[Chart]

*Mr. Latta. And this is important because, you know, one of the little graphs that was handed out earlier today in our binders, it just shows -- the graph here just shows the number of deaths from overdoses, and this only goes through 2021. But we also know that was 106,000, almost 107,000 in 2021. We know it is up to 109,000. It is not going down, it is going up.

And the other thing about these is, you know, if we look at a graph, we just see statistics. These are humans. And so I think this is why it is important that we are having this discussion today.

And again, I am proud that you are all -- that I am leading legislation with my friend, the gentleman from California's 25th district who was included in today's

hearing. It is a step in the right direction.

In addition, I am also proud that the House passed the HALT Fentanyl Act earlier this year that I co-led with my friend and colleague, the gentleman from Virginia.

If I could start with Mr. Strait, tragically, the United States, you know, passed the second year in a row of over 100,000 -- 109,000, to be more accurate -- overdose deaths, of which one county sheriff told us we shouldn't really be talking about overdoses. In a lot of cases we should be talking about these are poisonings, not an overdose. And in some cases it is outright murder, and especially when we saw that, with fentanyl-related, that we went up to over 73,000 people passing because of it. Do you see -- are there any other legislative proposals now brought before this committee today that would be a game changer in fighting addiction?

*Mr. Strait. Well, from DEA's perspective, the single most important aspect of our ability to infiltrate and to prevent these controlled substances from -- or these substances from crossing our borders and being distributed by violent street gangs is through its control under the CSA. That gives law enforcement -- not only ourselves, but our law

enforcement counterparts at the border, our folks that are interdicting mail packages and mail parcels -- with authority to seize.

And then, obviously, it gives us to work -- the authority to work backwards and arrest individuals for trafficking those substances. So schedule I control is, by far, the biggest single thing that can be done to help us.

*Mr. Latta. Well, I think that is absolutely correct, and I know that -- the chair earlier had talked about that, permanently scheduling fentanyl-related substances. But it is also important that, you know, again, we just have to get this thing done, and it has got to be a schedule I.

And let me just ask, you know, just yes or no, do you believe that permanently scheduling fentanyl-related substances as schedule I is needed, no matter what the mandatory requirements are out there?

*Mr. Strait. Yes.

*Mr. Latta. Yes, and I think just real briefly on that, on the mandatories -- because I think, when you look at it, it is 100 grams of fentanyl. That is -- if you take that out to what it turns out to be, that is 50,000 lethal doses that

someone -- that you could kill somebody with. And I think that is really absolutely important.

Dr. Jones, do we anticipate any more aggressive substances that could be more deadly than fentanyl to enter the illegal drug market?

*Dr. Jones. We certainly see the proliferation of a variety of synthetic drugs coming in. And as was discussed earlier, it is fairly straightforward to modify the chemical structures.

So we have seen non-fentanyl based synthetic opioids like nitazenes emerge in the U.S. drug market. So it is very possible that other substances could be created and trafficked into the U.S. Whether they are opioids or synthetic benzodiazepines, cannabinoids, or synthetic stimulants, we see sort of a constellation of synthetic drugs that are fairly straightforward and easy to produce in labs.

*Mr. Latta. Well, I appreciate that.

And Mr. Chairman, my time has expired and I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Ms. Kelly for her five minutes for questions.

*Ms. Kelly. Thank you, Chair Guthrie and Ranking Member

Eshoo, for holding today's critically important hearing.

In Illinois, the leading cause of pregnancy-related deaths is due to mental health conditions, including substance use disorders, which comprise 40 percent of pregnancy-related deaths. This aligns with the national trend of substance use being a leading contributing factor of maternal death.

Pregnant and postpartum women who misuse opioids are at a high risk for poor maternal outcomes, including pre-term labor and complications related to delivery, problems frequently exacerbated by malnourishment, interpersonal violence, and other health-related social needs.

Infants exposed to opioids before birth also face negative outcomes, with a higher risk of being born pre-term, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome, where babies go through drug withdrawals after birth.

I am pleased to hear about all the investments from the different agencies to address substance use disorder and pregnant women.

Mr. Blum, in your testimony you speak about the maternal

opioid misuse model that has been established in seven states. I am elated that there are 983 women participating in the model. But how do we expand this program to increase participation, and what efforts are there to increase the diversity in the participation pool?

*Mr. Blum. Thank you for the question. This model is relatively new for CMS, and so we are still learning the overall data impacts. Participation has been relatively small, just about 900 or so beneficiaries. We want to expand that work. We want to really learn from what can be learned so far. But we agree that, for us to improve safety, to improve lives, to save mothers, to save babies, we have to better integrate services together.

*Ms. Kelly. And I would be interested in hearing, as you progress, how that is going. So thank you for your response.

Surgery is among the most common indication for opioid initiative, as opioids are routinely described for pre-operative pain management. Data suggests that there has been an increase in the amount of opioids dispensed following minor surgical procedures, and that many U.S. patients

receive more opioids than necessary to treat their short-term pain. This is why I am happy to work with my partner, Rep. Balderson, to introduce H.R. 4093, the Remote Opioid Monitoring Act of 2023, which requires a GAO study on the use of remote monitoring for patients who are prescribed opioids to better understand the efficacy, individual outcomes, and potential cost savings from this tool.

I am also married to an anesthesiologist, so we talk a lot about this.

Dr. [sic] Coderre, thank you for sharing your story. Thank you so much. With so many individuals having access to opioids due to outpatient procedures, is there a standardized process to ensure a safe monitoring of patients prescribed opioids once they are discharged home, and what additional support should be provided?

*Mr. Coderre. Well, thanks so much for that question, Congresswoman.

At SAMHSA, you know, we fund the full continuum of programs related to prevention, intervention, treatment, and recovery support. And so, as it relates to safe monitoring of opioids, that is not my area of expertise, but I would be

happy to have our staff work with your staff to get you some data and some of the resources from some of our programs to respond to you.

*Ms. Kelly. That would be great. Also, is alcohol use disorder an allowable use of funds for other grant programs such as the Substance Use Prevention Treatment and Recovery Support Services Block Grant?

*Mr. Coderre. Thanks so much for that question. Yes, certainly, alcohol is an allowable use of state substance use block grant dollars. The Chair asked me earlier about the SOAR program, and I neglected to mention that, while SOAR is for opioids and stimulants, if somebody has a co-occurring alcohol use disorder SOAR funds can also be used in that program.

*Ms. Kelly. So let me ask. Would adding alcohol use disorder as an allowable use for the state opioid response grant program, would that take away funds from the existing opioids response program?

*Mr. Coderre. Well, certainly, Congresswoman, it is a zero sum game. So if you add something to the program, there will be less resources available for the other parts. But as

you point out, the substance use block grant is a vehicle that states are currently using to fund these programs, and we have a few other programs at SAMHSA that they are using, as well.

*Ms. Kelly. So I will just let you know I would support an increase in funding for a new program.

*Mr. Coderre. Thank you so much.

*Ms. Kelly. With that I will yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Mr. Bilirakis for his five minutes.

*Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it.

I would like to ask for unanimous consent to insert into the record two letters, one from the American Veterinary Medical Association and key animal health and medicine stakeholder groups, and the other from 39 state attorneys general, both letters urging passage of the bipartisan bill I co-lead with Representatives Panetta and Representative Pfluger, the Combating Illicit Xylazine Act, H.R. 1839.

*Mr. Bucshon. Without objection.

[The information follows:]

1888

1889 **********COMMITTEE INSERT**********

1890

*Mr. Bilirakis. Thank you.

*Mr. Bucshon. So ordered.

*Mr. Bilirakis. I would also -- thank you -- I would like to ask for unanimous consent to insert into the record a letter from the National Association for Children's Behavioral Health in strong support of my bipartisan bill, the Ensuring Medicaid Continuity for Children on Foster Care Act, which I lead with Representative Castor.

*Mr. Bucshon. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bilirakis. Thank you. So my first question is my bill will ensure that qualified residential treatment programs are exempt from being considered as institutions for mental disease, which are prohibited from drawing down Medicaid funds for medical services. QRTPs are one of the few residential settings that have strong oversight and accountability due to the Federal qualification accreditation requirements, improving outcomes for children with acute mental health needs.

Unfortunately, QRTPs have been inadvertently -- I really believe this -- inadvertently considered as IMDs under the law, which could prevent additional options for foster children in need of care. I was glad to see CMS supports this change, since it allows states to lift the IMD exclusion for QRTPs under the 1115 waiver. I do believe -- I do not believe that QRTPs were ever intended to be considered IMDs.

And while I strongly support the goal to ensure all foster children get placed in family home settings, unfortunately the reality is there is a shortage of licensed foster homes available for children in need of care -- unfortunately, again, it is very sad -- and reports have

recently revealed some states have resorted to, believe it or not -- and I have the article here -- putting foster kids up in casino hotels and juvenile detention centers, and other desperate settings since, sadly, they have nowhere else to go. We have got to rectify this.

QRTPs can help fill this clear continuity of care, again, with the Medicaid program by providing qualified care on a temporary basis. So Mr. Blum, will you commit to working with us to ensure that foster children have the appropriate Medicaid coverage for medical services in appropriate settings that can provide care for their mental and behavioral health needs? If you could answer that, I would appreciate it.

*Mr. Blum. Yes, sir. We would be very happy to work with your office.

*Mr. Bilirakis. All right, very good. Next question. I don't have a lot of time. Next question.

Dr. Jones, you spoke to CDC's drug overdose surveillance and epidemiology system, and the work that is being done to collect and analyze data to better understand the opioid overdose epidemic. It seems to me that electronic health

records and hospital discharge records may only provide a narrow scope of information, since many struggling may not officially use the health care system or seek care.

As the substance abuse epidemic shifts, I believe we must also shift our data collection mechanisms. What role could wastewater surveillance, which is appealing because it protects individual privacy, play -- so what role will it play in identifying clusters of drug utilization and changes in trends in suspected drug overdoses at the local, state, and regional levels? What role can that play, the wastewater surveillance, please, sir?

*Dr. Jones. Thank you for the question. Certainly, we have seen the value of wastewater in response to COVID. We have used that same approach for Mpox and other infectious diseases.

There are ongoing discussions about how do we best utilize the potential for wastewater surveillance in the overdose crisis. We have prioritized dose, which you mentioned, as a syndromic surveillance system, toxicology data, emergency medical services data, other data that can connect the substances being used with the outcomes we are

trying to prevent.

But there is an interagency group that is really thinking through what are the ethical resource needs, what are the community acceptability levels for drug-related wastewater testing. So it is an active area of discussion. I am certainly happy to come back to the committee and work with the committee as we continue to explore how best to use wastewater within the context of the systems we already have.

*Mr. Bilirakis. Please, I appreciate that. I think we are on to something.

Thank you very much, and I yield back.

*Mr. Guthrie. [Presiding] Thank you, the gentleman yields back. The chair now recognizes Dr. Schrier for five minutes for questions.

*Ms. Schrier. Thank you, Chair Guthrie, and thank you very much to the witnesses who are here today.

In my state of Washington, like every other state that you have heard, substance use continues to rise, and overdeaths -- overuse deaths and overdoses have increased. And in fact, opioid drug overdose deaths in the state nearly doubled in just 2 years, from 827 in 2019 to over 1,600 in

2021. And that number is continuing to rise, as we are seeing in every state.

Fentanyl has dramatically added to this picture with profound and devastating impacts, including in people who have never used any drug before.

In Chelan County, a rural county in the eastern part of my district, the coroner recently reported that the number of deaths adjusted for population is actually 10 times higher than the rest of the state. And I don't believe this is unique for rural America. The numbers and absolute numbers were from 6 to 20, but when you look at that as a percentage of population, it is quite high.

So the people in my district and all over this country are concerned. I have talked with parent groups about the hard conversations that they need to have with their children -- I am also a pediatrician -- so how to talk with your tweens and teens early about never accepting any pill from anyone other than a pharmacist. I have held multiple roundtables in my district to bring families together with local officials, law enforcement, behavioral health providers, schools to talk about the impact of opioids and

fentanyl use. And I have had conversations with mayors and Homeland Security just about how we can prevent harm and stop this from flooding into our communities.

I wanted to first focus on this epidemic in rural America because it seems to be hitting there even harder, despite what many might expect. As I mentioned, Commissioner Overbay told me about these increasing numbers. One of the worries in rural America, like with all other health care, is do we have the workforce, and do we have the resources to treat substance use disorder there?

And so, Administrator Espinosa, this question is for you. You talked about several programs specifically directed at rural populations. And I was wondering if you could just expand on those and how reauthorizing the SUPPORT Act will help in rural communities.

*Ms. Espinosa. Sure, thank you for the question. As I mentioned, you know, HRSA has a strong focus on supporting rural communities. As you note, there are unique issues there, particularly in the workforce.

The Public Health Service Act Section 756 Program, which is -- which the committee helped reauthorize in the omnibus,

is a valuable tool for us. We are training professionals, clinical social workers, psychologists, and others. And a key factor is that we train them in community-based settings in rural and underserved areas. And the importance there is that people who train in areas are more likely to go on and practice there. In addition, while they are training, they are providing services in the community.

We have also, through that program, supported families. So we have a family support program that focuses on community health workers, peer support professionals, because, as many have remarked, the substance use disorder issue impacts not just the individual, but their whole family and their community. And so those supports are particularly important for prevention, and also for making -- helping people stay retained in care.

And then --

*Ms. Schrier. Can I ask another -- just a tangential question? Because you talked about mental health support, which is so important. But we also know that we just don't have the number of practitioners. Many of these substance use disorders began with an injury, and with a need for good

pain management. And so another thing I have heard in rural communities is we don't have a pain medicine specialist anywhere near here who can help address that. Is that at all included, or is that one of the things you are focusing on?

*Ms. Espinosa. We have included pain management as a component in the programs that we have authorized. For example, we have an addiction medicine fellowship program. So in that training, pain management is a component there.

Similarly for the graduate psychology program, where doctoral-level psychologists -- so where we can, we are including that as a component of the training.

*Ms. Schrier. Thank you. It sounds like a great use of telemedicine.

I only have 14 seconds left, so I am just going to highlight the importance of addressing adverse childhood experiences and ACEs in the risk for teens and children to, you know, become victims of substance use disorders.

And I want to thank you, Dr. Jones. I was going to direct a question to you; I just want to thank you for focusing on children.

Thank you, I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes Mr. Johnson for five minutes for questions.

*Mr. Johnson. Well, thank you, Chairman Guthrie. You know, in 2021, according to the CDC, Ohio had the fourth highest number of overdose deaths of any state in the nation. Every day when I am back home in Ohio's 6th congressional district I am told heart-wrenching stories about this plague that has swept across Appalachia, and that has ended so many young lives. It is no secret that eastern Ohio, where I call home, has been hit particularly hard by the opioid crisis.

As a member of the bipartisan Fentanyl Prevention Caucus and the bipartisan Mental Health and Substance Use Disorder Task Force, I have witnessed firsthand the power of bipartisan work in addressing the epidemic.

Opioid addiction does not discriminate based on gender, age, race, social status, or political view. It takes no prisoners.

The work that our committee, frequently recognized as the most bipartisan committee in Congress, the work that we have done to combat this scourge is one that I commend.

Whether it be the SUPPORT Act, the largest, most comprehensive legislative response to the opioid crisis, or our continued work eliminating barriers to mental health care and telehealth services, these efforts are making a difference.

So my first question goes to Dr. Jones.

In your testimony you mentioned the CDC's overdose data action prevention program and how it is used to understand the drivers of overdoses. You specifically referenced my home state of Ohio. And in fact, the Stark County Health Department in my district is using a geographic information system to pinpoint areas in the county that are being hit hardest by opioids, and then share that data online.

Stark County, home to Canton and the Pro Football Hall of Fame, alone has seen over 500 overdose deaths since 2012. Could you explain the real-world life-and-death impacts that these types of data-sharing software and mapping has on communities? Are they helping bend this devastating curve in the other direction?

*Dr. Jones. Thank you for your question.

I mean, I think data are really foundational to

understanding what is happening in a community, who is at risk, and how is risk changing, and where should we deploy resources. And that is really the goal of our support to health departments, is to use the near-real-time syndromic data, use emergency medical services data, use mortality data to really tell that story for a community.

There might be assumptions that a community has that this area is more impacted than this area, but really using data to say, in fact, it is here where we need to be deploying resources -- and so, especially with quick response teams, spikes in overdose with a toxic drug market, these near-real-time data allow communities to rush in resources to connect people post-overdose to care, so that they can receive lifesaving care --

*Mr. Johnson. In other words, follow the facts, follow the science, right, and you make better decisions.

A key component to combating opioid abuse is addressing pain care and ensuring patients and providers are informed of the continuum of non-opioid pain therapies. In 2019 HHS released its Best Practices for Pain Management Task Force recommendations with the goal of improving safe, effective,

evidence-based pain care in America. Unfortunately, the recommendations of this task force have not reached wide -- widely reached clinicians.

So Mr. Blum -- have I got that right? Bloom or Blum?

*Mr. Blum. Blum, sir.

*Mr. Johnson. Blum, I am sorry. What has HHS done to distribute the task force recommendations?

And will you commit to developing and implementing a strategic plan to widely disseminate those recommendations to clinicians?

*Mr. Blum. Thank you for the question, Congressman. We agree that CMS programs certainly need to do more to expand --

*Mr. Johnson. What has HHS done?

*Mr. Blum. We continue to work with care systems to identify better pathways for pain management services, but I am happy to work with you to find ways for us to improve.

*Mr. Johnson. Okay, all right. Well, I had another question, but my time has expired and -- or close to it. But thank you folks for being with us today. Obviously, we have got a lot of work to do to wrestle this scourge to the

ground. And I appreciate all that you are doing to help us get there. Thank you for being here today.

I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Sarbanes for five minutes for questions.

*Mr. Sarbanes. Thanks very much, Mr. Chairman. Thanks to all of you for being here.

We know it is a theme here today, and it is a persistent one in many hearings, that our communities are facing a mental and behavioral health crisis, and no community has been left untouched. We know that because every Member of Congress is stepping into this conversation in a meaningful way.

I am pleased that the subcommittee is holding this hearing today to discuss the reauthorization of so many important programs that work to address these challenges.

I do have to note that this week, unfortunately, however, the House will consider legislation to continue the Republicans' attempts at undoing the Affordable Care Act, to undercut the accessibility of comprehensive and quality

health care coverage for millions of Americans across the country, including many with substance use disorders.

The committee is also considering some legislation today that gives me some pause because I worry about it having potentially similar impacts. We all know that telehealth has been vital to improving timely access to care, particularly in underserved and rural communities, and there has been some real advances over the last few years -- a lot of that forced by the pandemic -- on the telehealth front. But I do have concerns with H.R. 824, the Telehealth Benefit Expansion for Workers Act.

Contrary to what the title suggests, I think the bill could actually put workers at risk of losing their access to the comprehensive kind of health coverage that they should have. By expanding accepted benefits -- that is a phrase we have come to know -- accepted benefits programs -- which is sort of a form of these junk plans that we worry about that aren't subject to the ACA's consumer protections -- the proposal would allow more employers to offer these plans, these sort of less-than-comprehensive and, really, in some cases, shoddy plans, instead of ensuring all eligible workers

are able to enroll in comprehensive group health coverage.

Accepted benefits are not subject to the ACA's protections for people with preexisting conditions or subject to the ACA's mental health parity requirements, and they aren't subject to the ACA's out-of-pocket spending limits, bans on annual or lifetime limits, or the requirement that insurers spend at least 80 percent of their premiums on actual health care, as opposed to CEO pay and profit.

Mr. Blum, am I accurately characterizing what these accepted benefit plans are missing?

*Mr. Blum. I believe so, yes, sir.

*Mr. Sarbanes. Thank you very much. So a proposal like this would put vulnerable Americans, including those with mental and behavioral health challenges, at risk and without reason. Mr. Blum, is there any reason that employers who already have significant flexibility to offer telehealth coverage -- I mean, you can do that as part of a plan -- would they be prevented from doing so as part of their comprehensive coverage approach?

*Mr. Blum. No, sir.

*Mr. Sarbanes. Thank you. When we weaken consumer and

parity protections, we are undercutting our response to the ongoing mental and behavioral health care crises, and raising health care costs for everyone. Instead, we should be focusing our energy on building up programs that are proven to help address these challenges.

I will switch gears here now, and talk about one such program that is doing that. It is the Substance Use Disorder Treatment and Recovery, or START Loan Repayment Program. I was pleased to be able to play a role in developing this program in 2018, along with Chairman Guthrie, because I knew it was critical to create these kinds of incentives for individuals to serve their communities as behavioral health care providers.

Ms. Espinosa, can you comment on the impact that this program has had in strengthening our behavioral health care workforce pipeline since its inception, and the resources that are necessary now to ensure that it can reach the most providers and ultimately promote access to care for the most patients?

*Ms. Espinosa. Thank you for the question, sir.

The STAR LRP program has -- is currently supporting 445

people that are in the field providing direct patient care right now. We are going to make some additional awards this year by the end of the fiscal year, and that will be over 600. It has a tremendous impact in expanding the types of sites that can receive this type of support. Loan repayment is critical in some places in being able to attract the workforce that you need. It provides the providers, the employers an additional incentive that they can offer folks.

And so we have also been able to greatly expand the types of providers. And so we are -- these are people that are now working in both inpatient and outpatient, paraprofessionals that are working as peer support counselors and throughout the community. So it has had a significant impact in targeting that particular gap in supporting the workforce.

*Mr. Sarbanes. That is terrific. We look forward to hearing about how it continues to scale up.

With that, I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now recognizes Dr. Bucshon for five minutes for questions.

*Mr. Bucshon. Thank you, Chairman Guthrie, and thank you to the witnesses for being here today.

We have people in ERs, in jails, and on the street with substance abuse disorder. We are doing them a disservice, and we all have to do better.

The SUPPORT Act contains several critical policies to reduce opioid-related harms by improving pain management and patient awareness of and access to non-opioid treatments, including FDA-approved medical devices, non-opioid medicines, and other therapies.

Unfortunately, five years after passage, there are several provisions of the SUPPORT Act where the executive branch has failed to fully implement policies or to meet required deadlines.

Mr. Blum, I have been a big proponent of breaking down reimbursement barriers to increased adoption of non-opioid alternatives. Congress has worked in a bipartisan fashion to unbundle non-opioid payments from the ambulatory surgery center and hospital outpatient setting to spur adoption of new and innovative non-opioid treatments. However, I am concerned with inconsistent coverage policies that are

harming patient access.

I do believe we are in a critical phase concerning how CMS makes or doesn't make national coverage decisions for innovative medical therapies in a timely and appropriate manner. More specifically -- and this is related to Medicare Administrative Contractors -- I have heard from physician organizations that they have implemented far more restrictive policies for non-opioids in the face of an existing National Coverage Decision which, by law, they are not allowed to do. Can you tell me what CMS is doing to enforce NCDs?

Should Congress look to clarify that MACs are not allowed to have more restrictive coverage policies, particularly for non-opioid alternatives?

*Mr. Blum. Thank you for the question, Congressman.

By statute we have a Medicare coverage framework that delegates much decision-making for coverage to MACs. That is one fundamental tenet to our statute.

CMS works hard to oversee that process. And whenever we hear concerns that MACs aren't following the law, aren't following processes, aren't following notice and comment, that we are comfortable to step in to ensure strong

oversight.

*Mr. Bucshon. That is great, because it is not working, just so you know. I am hearing that from not -- I am not directing this at you personally, I am directing this at the agency.

And why is that? Well, let me see. Opioids cost almost nothing, and non-opioid alternatives are expensive in many cases. Makes sense, right? So you have administrative contractors limiting access to non-opioid alternatives. It is unacceptable. CMS needs to do better.

Question number two, continuing with the issue of reimbursement for non-opioid alternatives, as was mentioned by Ranking Member Eshoo, CMS has yet to release the Todd Graham Pain Management Study, section 6086 of the SUPPORT Act, five years later, which directs CMS to revise payment and coverage of non-opioid pain treatment options. We need the data. It seems CMS is dragging their feet. I don't know why. It seems CMS has -- drags their feet a lot. I work with them a lot, and it has taken years sometimes to get innovative treatments covered that are approved by the FDA, by private insurers, by the VA. We have to do better. We

need this data so we can move forward.

And on the topic of implementation, the CMS Opioid Action Plan, section 6032 of the SUPPORT Act, was released in 2021. How has CMS adopted the action plan to revise payment and improve coverage of devices, non-opioid medicines, and other therapies?

*Mr. Blum. Thank you for the question. The CMS has worked hard to implement all of the SUPPORT Act provisions. We are happy to follow up with any specific concerns of areas that we are falling short.

*Mr. Bucshon. Time is of the essence. And Mr. Chairman, as I said and I implied, CMS should not be the limiting factor related to access to FDA-approved medical therapies or devices. This needs to end. CMS needs, in my opinion, top-to-bottom reform. It is overly bureaucratic, and it takes years to get approval and access to devices and medical therapies to patients. I have personal experience with this. I have been in Congress -- this is my 13th year.

So I implore us to do something about these unnecessary delays that are limiting the access to alternatives to opioids because opioids are very, very cheap, and non-opioid

alternatives may not be. And so funding and paying for these things is limiting access, I think, based on finances. And that is just unacceptable.

I yield back.

*Mr. Guthrie. Dr. Bucshon yields back. The chair recognizes Mrs. Dingell from Michigan for five minutes for questions.

*Mrs. Dingell. Thank you, Mr. Chairman, and to you and Ranking Member for convening this really important hearing.

Many, if not all of us, have deeply personal stories of losing loved ones, friends, and constituents to opioids and addictions and the fentanyl. With the growing opioid and fentanyl crisis, these stories are becoming distressingly common. So it is important that this subcommittee is taking action to address this crisis with the urgency it requires, including expanding upon the important progress we have made through the enactment of the SUPPORT Act in 2018.

As we work to continue responding to this crisis -- and I agree with my other colleagues who say we are not going fast enough; someday we are going to get something that somebody will prescribe that is not addictive like opioids

for pain relief -- it is critical that we authorize key provisions that are set to expire at the end of this year.

The SUPPORT Act authorized a pilot program to improve coordination between public health laboratories and those operated by law enforcement to better detect fentanyl and other synthetic opioids. Dr. Jones, you mentioned that the CDC is strengthening public health testing by developing advanced laboratory tests for fentanyl. How can lab testing improve our understanding of opioid trends and new, emerging threats?

*Dr. Jones. Thank you for the question. I think it is a really important point that we are in a very dynamic, illicit drug market where new emerging substances need to be identified as quickly as possible so that communities can respond to those threats.

That provision in the Public Health Act, unfortunately, has not been appropriated, but we have used funding through our overdose line to support our public health lab work, developing reference materials, traceable opioid material kits, as well as other reference standards that public health as well as clinical labs can use to try to stay on the

cutting edge of what is emerging in communities.

And I think the components of that section are also important about public health and public safety working together. We are here together with DEA. We share information. We work closely together at the Federal level, but we are also supporting that work at the state and local level, as well. Through our overdose response strategy we pair up drug intelligence officers and public health officials to share data, to share information, to have a common operating picture of what is going on, what is emerging, and what do we need to do together to advance solutions to the crisis.

So having that data is absolutely critical, so that communities can understand how is it changing, how do we need to change tactics to address emerging threats.

*Mrs. Dingell. Thank you, I agree with that. I am going to do a question for the record on the -- working with the other labs.

[The information follows:]

**********COMMITTEE INSERT**********

*Mrs. Dingell. But I want to move to another question. Last week I introduced the FIND Fentanyl Act with Representative Bilirakis to reauthorize the SUPPORT Act's lab pilot program through fiscal year 2028. And I am grateful that this bill is included as part of today's hearing. And thank you to Rep. Gus Bilirakis for his partnership on this important effort. So we are going to work it.

Now I want to shift our focus a bit and talk about the importance of ensuring people in recovery can access the care they need, surrounded by their families and friends. As many of you know, I have worked very hard to ensure -- not getting there yet -- that folks can access care in home and community-based settings, or HCBS. We know that, given the choice, most people would prefer to remain in their homes and communities while they receive treatment, rather than being sent off to an institution. And that is why I am concerned about policies that could lead to an increase in people being in institutions.

Mr. Blum, there are two bills before us today that would further weaken the Institution for Mental Disease, or IMD, exclusion. Other than the state plan amendment that

Republicans would like to extend, are there other options for state Medicaid programs to cover IMD stays?

*Mr. Blum. Thank you for the question. Today CMS works with states to help design comprehensive systems that provide coverage for the full spectrum of care services that can best meet patients where they want to receive those services.

*Mrs. Dingell. So that is what I thought. So for the record, so a state that wants to cover IMD stays in Medicaid has options, even if this option were to expire.

I also want to ask about the waivers you mentioned. It is my understanding that a condition of those waivers is that states must support a continuum of care. Mr. Blum, can you talk about why it is important that individuals seeking treatment have access to care in more integrated settings in their homes and communities, and not just care in IMDs?

*Mr. Blum. Well, we know that patients prefer to receive services in different care settings. And we also know that one size doesn't fit all. And so work today that CMS does is to work in close partnership with states to ensure that we can help support programs that best meet those needs. And one principle that we believe is vital is that we

provide -- help support states to provide services to that full spectrum.

*Mrs. Dingell. I know I am out of time, Mr. Chair. I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes Mr. Carter for five minutes for questions.

*Mr. Carter. Thank you, Mr. Chairman, for holding this hearing, and thank all of you for being here.

Dr. Jones, it is always good to see you. I appreciate you all being here.

Mr. Strait, I want to ask you, the DEA released two proposed rules back in March that would govern the prescribing of controlled substances via telemedicine following the COVID-19 public health emergency, of course. And there were many, many comments from stakeholders on this.

And in May the agency and SAMHSA released a temporary extension of COVID-19 health emergency waiver authorities that allowed for some controlled substances, anyway, to continue to be prescribed via telemedicine without an in-person visit through November 11th of this year. It is my

understanding that this temporary extension will give DEA and other agencies the -- more time to review and respond to these comments as part of the rulemaking.

You well understand it is critical for patients across the country that the DEA process the final rules in a way that is going to balance patient access with concerns about diversion. I mean, we are concerned about diversion. There is no question about that. But we also need access, especially, especially for those patients that are utilizing buprenorphine as a medication to treat opioid use disorder.

If the DEA has not completed the rulemaking process by the November deadline, can you assure and commit to issuing another temporary extension so that patients can retain access to this care that they need?

*Mr. Strait. Thank you for the question, Congressman.

First of all, I want to say, from DEA's perspective, we believe that telemedicine is medicine. Telemedicine is here to stay.

*Mr. Carter. Right.

*Mr. Strait. But with that we also want to acknowledge the fact, you know, that this rule impacts the delivery of

health care for every American, and we want to make sure we get it right.

So we, obviously, did get a robust response to our proposed rules, 38,000 comments, as has been noted previously. And we want to make sure we are giving a thoughtful review, again, to make sure that we are getting it right, because we know how important this is.

*Mr. Carter. Okay. So can you commit that you will extend the date if you don't have it done by then?

*Mr. Strait. Well, we definitely believe that the six months is going to be sufficient to do an adequate review of the comments, but we are not going to let these vital services lapse.

*Mr. Carter. Okay, good. All right. Very quickly, I want to turn to another piece of legislation that I am leading, along with Congresswoman Schakowsky, who is waiving onto this subcommittee today. It is H.R. 4096, and it is pending before the committee today. It is legislation that standardizes the oversight and reporting of anti-psychotic medications prescribed to Medicaid recipients.

I was really alarmed at a GAO report that found

extraordinarily high rates of schizophrenia diagnoses and other psychotic disorders among Georgia Medicaid recipients. It looked like an outlier to me. I was just taken aback by that.

But this is very important. It is important to note and it is disturbing to note that GAO also found a high anti-psychotic use in Georgia, over 90 percent, over 90 percent of the beneficiaries with intellectual or developmental disabilities in Georgia with schizophrenia had used anti-psychotic medications. And this suggests that there might be an over-prescribing problem, especially in Georgia.

Mr. Blum, what actions can CMS take to monitor the prescribing of anti-psychotics?

*Mr. Blum. Thank you for the question, Congressman. We, too, are very concerned, alarmed at those same numbers. We have taken strong steps to better collect information from nursing homes that serve Medicare and Medicaid patients, and we are prepared to take strong steps when we see prescribing that doesn't meet clinical standards.

*Mr. Carter. Okay. All right.

At this time, Mr. Chairman, I am going to yield to

Congresswoman Schakowsky, if she -- she is leading this legislation with me.

*Ms. Schakowsky. Thank you, Representative Carter. I just want to say how happy I am to join this. For a long time I have been very concerned about the overuse of anti-psychotics for the purpose, really, of restraint.

And I, too, I just wanted to ask Mr. Blum, are you -- do you have any estimation of how -- I am assuming lives would be saved if legislation like this would be would be passed, and I wondered if you could comment on that, because the FDA has said that these drugs can kill up to 15,000 nursing home residents every year.

*Mr. Blum. We share the view that lives will be saved. We share the view that quality of care will improve. We know from clinicians there are legitimate uses for prescribing, but we also know that we have seen spikes that can't be explained. So we share the goal that you have, and I am happy to work with you to ensure that we can move forward better.

*Ms. Schakowsky. Thank you.

Thank you, Mr. --

*Mr. Carter. And reclaiming my time real quickly, I was a consultant pharmacist in nursing homes for many years, and I have seen chemical restraints like this. And this is a big problem. So I hope that CMS is looking at this diligently and very closely.

*Mr. Blum. I can assure you that we are, Congressman. I can also assure you that we are hearing very strong pushback. But CMS will stand strong, and we share the goal that you have.

*Mr. Carter. Great. Thank you, and I yield back. Thank you.

*Mr. Guthrie. Thanks. The gentleman yields back. The chair recognizes Dr. Dunn for five minutes.

*Mr. Dunn. Thank you very much, Mr. Chairman.

Mr. Strait, we know that we have shifted from a prescription opioid crisis to a new crisis now surrounding illicit fentanyl. But we have also seen Xylazine being used as an adulterant to the fentanyl and its analogs. This is the reason I cosponsored the Combating Illicit Xylazine Act, which we think will help law enforcement better track the information and enforce the law against traffickers

distributing it illegally.

Now, this is a delicate policy because I recognize that this drug, you know, represents the unique challenges of a regularly-utilized FDA-approved drug in veterinary uses, and it is safe in animals. But it is, obviously, quite deadly in human beings, so we want to make sure we strike the right balance. Can you briefly speak to the importance of the policy, and perhaps how we could do that best, how we can empower the DEA to address Xylazine as an illegal adulterant, but yet a legal drug in veterinary medicine?

*Mr. Strait. Sure. Thank you for that question. And it is the same kind of delicate balance that we are talking about at DEA, as well, and you described it perfectly.

On the one end, we know it is being encountered with fentanyl and creating potentially devastating consequences on people who would unsuspectingly use it. But at the same point, we also know that it has got widespread veterinary applications, specifically in large animals. So we too want to strike the appropriate balance on what makes best to protect public safety, while also ensuring that it is available for public health. And we are kind of not ruling

any options out.

As Congressman Pallone mentioned at the outset, we know that there is an interagency process and some executive branch procedures underway, but we also welcome the opportunity to work toward a legislative solution, as well.

*Mr. Dunn. Well, we would love to work with you, would love to see -- I don't think the people who are out of the medical practice -- out in the medical world actually appreciate the difference between this and fentanyl. When we say fentanyl, we mean the analogs of fentanyl, which are clearly not legal drugs. And now we are talking about an illegal drug being used as an adulterant in an off-label way -- way the hell off-label, out-of-the-species-label way.

So it is, it is a little bit of a different problem for us. But I think -- I trust that we can do this, and do it with alacrity. So I look forward to working with you. Thank you very much.

Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Ms. Barragan from California for five minutes of questions.

*Ms. Barragan. Well, thank you. Thank you, Mr. Chairman.

Mr. Blum, thank you for CMS's steadfast work to encourage states to apply for the new Medicaid reentry waiver program.

On January 26, 2023, CMS approved California's section 1115 waiver request, which is a first in the nation to include a partial waiver of the Medicaid inmate exclusion policy for justice-involved individuals for up to 90 days prior to release.

In December 2023 Congress passed bipartisan changes to the Medicaid law to require state Medicaid programs to start covering services for young people in juvenile detention 30 days prior to their release to help them transition back to their communities.

What progress is CMS making to implement the changes, and how would the implementation of this legislation interact with California's 1115 waiver?

*Mr. Blum. Thank you for the question. We were very happy to work with California to put in place this new waiver. CMS wants to -- would welcome working with other

states. We share the goal that California has to ensure that whatever we can do to continue coverage for services keeps going forward. CMS today welcomes, but also encourages more states to follow California's lead.

*Ms. Barragan. Okay, thank you.

In the five years since the SUPPORT Act was first passed, the opioid epidemic has evolved, and some challenges have continued to grow. One of these challenges is how the opioid crisis continues to fuel increases in deaths for people who are experiencing homelessness.

According to the Los Angeles County Department of Public Health, between 2017 to 2019 people experiencing homelessness in LA County were more than 36 times more likely to die of a drug overdose compared to the general LA County population.

Mr. Blum, can you discuss the innovative strategies CMS is testing to address homelessness and other housing stability needs for individuals with substance use disorders?

*Mr. Blum. Thank you for the question. We have started to work with states, California being one, to test ways for us to expand services that help to support better health care outcomes.

One of those services that we are -- very early testing of is limited, but carefully designed housing programs. These programs are new, are just starting, but we see further interest from other states for similar care models.

*Ms. Barragan. Okay. Well, this is an issue that I think is going to be very important on addressing homelessness. It is, I think, one of many of the factors into going -- why, you know, we are seeing the numbers go up, and making sure we are providing assistance to folks.

Now, substance use disorder can be both a cause and a consequence of homelessness and a significant barrier to exiting homelessness. Stable housing plays a vital role in the recovery process for individuals who are experiencing or at risk of experiencing homelessness. And so states are increasingly testing, evaluating, and advancing best practices around providing housing-related and recovery services and supports for Medicaid-eligible individuals.

Mr. Blum, what are some of the lessons learned by CMS or states regarding the Medicaid waivers approved under section 1115 or 1915, and how Congress can use these lessons to improve upon existing CMS authorities, or maybe create new

ones to ensure that Medicaid resources for housing-related services are coordinated and easily accessed by the people in need?

*Mr. Blum. Thank you for the question. These services are new, they are relatively new. I don't think we have sufficient data to come back to this committee to say how permanent policy can be best designed.

But what I can say, we are happy to stay in touch. We are happy to report progress as California, but other states move forward with these new innovations.

*Ms. Barragan. Great, thank you.

Ms. Espinosa, health care centers have identified behavioral health as the highest priority for service expansion, and they continue to play a critical role in reducing overdose deaths and improving mental health. Could you please explain how HRSA-supported Community Health Centers collaborate with community-based organizations to increase access to behavioral health services?

*Ms. Espinosa. Sure, thank you. Our health centers have partners throughout the community that they use for referrals, bi-directional referrals. Health centers have

significantly expanded the behavioral health services they have provided since they started making targeted investments, increasing behavioral health -- mental health by about 50 percent and substance use disorder by doubling it.

So they have been able to leverage these, but they are still not meeting all the need, and that is why we think it is very important to continue the funding for health centers, so that we don't lose ground on this important service venue.

*Ms. Barragan. Well, thank you, Ms. Espinosa, for that excellent explanation.

You know, Community Health Centers provide comprehensive health care services, regardless of a patient's ability to pay, and a lifeline for so many individuals and families across the nation. I, for one, as a kid, we used Community Health Centers, yet they are only able to meet about 25 percent of the demand for mental health services. So that is one of the reasons me and my colleagues, Representatives Blunt Rochester and Kuster, have introduced a bill called the Health Center Service Expansion and Provider Shortage Reduction Act to provide funding in behavioral health service investments to support and expand behavioral health services

in about 1,400 health centers across the country.

So thank you all for your work, and for being here today.

And with that, Mr. Chairman, I yield back.

*Mr. Guthrie. Thanks. The lady's time has expired. So I note the clock didn't start exactly right, so we didn't give you an extra four or five minutes. You had your full five, I know, you are good. You are good.

So now the chair recognizes Dr. Joyce for five minutes for questions.

*Mr. Joyce. Thank you for yielding, Mr. Chairman, and to our witnesses for appearing here today at this critical legislative hearing.

This marks another important step in the legislative process as we work as a committee to reauthorize the SUPPORT Act, a process that -- Chairman Guthrie brought the subcommittee to Gettysburg, Pennsylvania, where we heard powerful and important testimony from my constituents. And I would like to thank Mike Straley, Police Chief Bill Saravala, and addiction specialist Dr. Mitch Crawford again for their input, and for sharing their firsthand experience with the

opioid and addiction crisis that we are currently facing. We were able to examine crucial questions, particularly access to recovery services and how we can improve upon the SUPPORT Act as we move forward.

I would also like to thank the committee for including H.R. 4097, the Mental Health Improvement Act, which I co-introduce with Representative Sykes here today. This bill reauthorizes 756(f) of the Public Health Service Act, which provides important grant funding for our behavioral health workforce.

Deputy Administrator Espinosa, can you please elaborate on your testimony on how this funding is used, particularly in rural areas like mine, to train health care workers and expand access to behavioral and mental health services?

*Ms. Espinosa. Yes, thank you for the question.

Our behavioral health workforce programs emphasize the importance of clinical training in those underserved communities and rural communities. So we are training professionals and giving them that experiential learning in those most underserved communities that has implications for where they go on to practice, since people who have

experience in those areas are more likely to go practice there, and it also expands services in those communities by having them as training sites.

We have also been supporting the paraprofessional workforce to support communities in the broader sense. Those are community health workers, peer support specialists, those key positions that help with prevention and help make sure that people in rural communities are retained in care, and then can help them overcome some of the obstacles for staying in care.

*Mr. Joyce. Thank you.

*Ms. Espinosa. So --

*Mr. Joyce. I continue to be very concerned about the increase in fentanyl poisonings that we are seeing across the country. And fortunately, the House recently passed the HALT Fentanyl Act to permanently place fentanyl-related substances into schedule I of CSA, and work toward getting these weapon-grade poisons off of our streets.

Mr. Coderre, in your written testimony you mentioned that the prevalence of synthetic and illicitly-manufactured opioids have led to a significant increase in overdose

deaths. How has the increase in synthetic opioids, including illicit fentanyl, impacted the way that SAMHSA communicates with treatment providers and disseminates what best practices are and what are available?

*Mr. Coderre. Thank you so much for that question, Congressman.

At SAMHSA, as you know, we are concerned with the full continuum of care for substance use disorders: prevention, treatment, recovery support, as well as intervention. And so we use our programs to communicate with states and local providers. We have a variety of centers of excellence that work with our folks on the ground to alert them of these dangers, provide them with the best practices for treatment and recovery support in these instances. But we would be happy to work with you and your team to identify ways we could do better.

*Mr. Joyce. Thank you. I look forward to that collaboration.

At the recent SUPPORT Act reauthorization field hearing that I mentioned in Gettysburg, I highlighted that improving pain management for the 50 million Americans in chronic pain

is a critical component in helping to combat our country's substance misuse crisis. Both the SUPPORT Act and its predecessor, CARA, had numerous policies to improve pain management, including the creation of the Pain Management Best Practices Task Force to make recommendations to improve pain care and to reduce opioid-related harms.

The task force called for individualized, multi-modal care, improved access to non-opioid therapies, and increased education on pain management best practices. Director Jones, did the CDC's updated opioid prescribing guidelines incorporate task force recommendations?

And what educational tools has the CDC developed, and how are they used to promote non-opioid options?

*Dr. Jones. Thank you for the question, and I certainly will underscore that the Pain Management Task Force was a very important piece of the SUPPORT Act in bringing people together to really elevate the conversation not just about opioids and what role they might play in pain, but also how we might look at pain more holistically.

The CDC guideline, which came out last year, repeatedly references the Best Practices Task Force document, and has

good consistency with those recommendations for how we approach pain care, and prioritizes non-opioid medications or non-opioid -- non-pharmacological treatments for pain, recognizing there is a role for opioids but in many cases non-opioid treatments may actually be the better option for patients to actually achieve their pain-related goals.

*Mr. Joyce. And I think all of those options need to be evaluated and continue to be evaluated.

Chairman, my time has expired, but again I thank you for bringing the Health Subcommittee on the important issue of the SUPPORT Act to Gettysburg, Pennsylvania, and I yield.

*Mr. Guthrie. Thank you. That was a wonderful trip. The gentleman yields back, and the chair recognizes Ms. Craig for five minutes for questions.

*Ms. Craig. Thank you so much, Mr. Chairman, and thank you to all of the witnesses for being here today. I am so heartened by the number of good, bipartisan bills that we are discussing here today.

But I want to be clear. We are in an American crisis. Over the course of this hearing approximately 21 people will die of a fentanyl overdose. That is why my bipartisan bill

with Mr. Griffith, the RECONNECTS Act, is so critical. It will provide Federal resources to our public health agencies to head off overdoses before they occur. This is an important issue, and I am glad -- really, really heartened -- that it is so bipartisan.

To start I want to focus my first question on the importance of this legislation in the continued fight against the opioid epidemic. Dr. Jones, can you talk a little bit about the function of prescription drug monitoring programs, and how they serve as a public health tool?

*Dr. Jones. Thank you for the question.

So prescription drug monitoring programs are state-based programs that capture information from pharmacies on controlled substances that are dispensed in that jurisdiction. They can be used as a clinical tool. So pharmacists, physicians, nurse practitioners, other prescribers can go into the system if they are treating a patient to see, has that patient been prescribed other medications by other providers, where there might be an interaction or there is some pattern of potential misuse so they can provide information to make those clinical

decisions.

But they also can be used as a data tool to help states understand what are the prescribing trends that are happening in a state, how might they vary across communities in their state, where might they deploy resources to support, whether it is addiction or better access to pain care?

*Ms. Craig. Thank you so much, Dr. Jones.

I want to note that the RECONNECTS Act explicitly designates the fentanyl crisis as a new and emerging public health crisis. To me this is a critical addition to current law.

Next I would like to touch on another new and emerging threat that our country is facing. Mr. Strait, earlier this year DEA issued a public safety warning of a sharp increase in the trafficking of fentanyl mixed with -- sorry, I can't see here today -- Xylazine. How has the introduction of Xylazine into the illicit drug market complicated DEA's efforts to combat the fentanyl crisis?

What do you need from Congress to better address the emerging threat of Xylazine?

*Mr. Strait. Thank you for that question. I didn't get

a chance to say this earlier, but in this current fiscal year about 25 percent thus far of our powder samples of fentanyl are containing Xylazine. And that, obviously, complicates kind of what you were talking about earlier with your previous -- with your legislation with trying to reduce the number of overdose deaths, because that is a complicating factor to how a patient may present, and the ability of Narcan to actually impact a positive outcome there.

So at DEA we are kind of taking a look at and seeing what options are available to us to have better data to understand where this Xylazine is coming from, and so that we can go back and try to, you know, try to address the threat where it begins.

*Ms. Craig. Well, I just want to say that we really appreciate all of your efforts in my district and across the country. There is absolutely no time to waste. Lives depend on whether we have the political will to act. I am ready to work with anyone to address these problems head on, and I am really grateful to my colleagues across the aisle who are doing the same.

With that, Mr. Chair, I again, recognizing the urgency

of this issue and the fact that we have no time to waste, I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes Mr. Crenshaw for five minutes for questions.

*Mr. Crenshaw. Thank you, Chair and Ranking Member. Thank you to the witnesses for being here today.

As we consider the SUPPORT Act, I want us to think of 21st century solutions to substance abuse. PTSD and substance abuse disorders often happen together. Forty-six percent of those with lifetime PTSD will also have substance abuse disorder.

One of the solutions I am working on is getting clinical trial guidance for psychedelic therapies, a guidance from the FDA, of course. And this therapy will be earth shattering. It already has been. It has already changed dozens of lives. I have dozens of testimonies from veterans and service members who have suffered severe traumatic brain injuries and severe PTSD -- they were on the brink of suicide -- whose lives were changed by these therapies.

It is not just veterans, it is also people living with

PTSD, whatever kind of trauma they have gone through. Civilians struggling with addiction have benefited massively, as well. The testimonies from each and every person who goes through these therapies is they no longer drink, and they no longer do drugs. They have no need for it after one day of a therapy with a drug called ibogaine, for instance. And this is not -- again, not just veterans, people like John Costa, who, after participating in a clinical trial at NYU, was cured of his alcoholism.

We are not talking about 1960s LSD trips. This therapy is supervised by a medical practitioner, often occurs with repeat treatments in a controlled setting.

And when it comes to the efficacy of this therapy, the proof is in the data, in the testimonies. But we need the FDA to issue clinical trial guidance for psychedelic-assisted therapy so that the industry can actually invest in this. Right now it is difficult for researchers to pursue these trials without any direction at all from FDA. Without that direction, it is even more difficult for us to conduct the research to tap into this breakthrough treatment option.

Unfortunately, I was told we could not get this

bipartisan bill noticed in today's hearing, but I would appreciate the chairman's commitment to put it in future markups.

*Mr. Guthrie. I will work with you.

*Mr. Crenshaw. Now I want to shift gears to the fentanyl issue.

Everyone on this committee should know that one of my top priorities is confronting the cartels head on. They are poisoning tens of thousands of Americans per year with fentanyl, and this is particularly true for communities in my district, like Harris County, where fentanyl and fentanyl derivatives kill at least one person every day. The cartels facilitate and take advantage of our open borders so that they can push deadly fentanyl into our country while Border Patrol resources are diverted to deal with mass influxes of migrants.

The cartels and their Chinese Communist Party allies are constantly changing the chemical composition to evade law enforcement. The new emerging threat is illicit Xylazine, which the cartels are mixing into fentanyl. It is cheaper to produce, easier to sell, produces a different high, severe

side effects.

I am supporting Representative Pfluger's legislation to permanently schedule illicit Xylazine so that we can actually prosecute traffickers with the penalty they deserve.

Mr. Strait, can you explain why you are unable to schedule drugs through the administrative process and need congressional action, and what type of congressional action?

*Mr. Strait. Well, thank you, Congressman Crenshaw. And I think you summarized the issue as well as my previous colleague who was here in February talking about this threat.

So the short answer to your question is that there is an administrative process that we are currently pursuing. We are taking an all-options approach at this point, and we are going to be considering our executive branch procedures for considering potential control under the CSA, as well as opportunities to work with Congress in the event that that could be potentially quicker.

*Mr. Crenshaw. Can we just talk in general about the fentanyl poisoning problem? And that is your description of it, that is my description of it, as well. It is a poisoning problem. What is preventing us from stopping this?

Is it lack of resources? Do you just not have enough agents on the ground?

Or is it lack of authorities? Can you not prosecute people effectively when they are caught dealing fentanyl?

Or is the only way -- is the only solution to target the actual source, the cartels in Mexico producing it?

*Mr. Strait. I think the targeting piece is certainly one of the most important aspects of this administration's approach to addressing the problem.

*Mr. Crenshaw. Targeting of cartels --

*Mr. Strait. Yes.

*Mr. Crenshaw. -- specifically within Mexico.

*Mr. Strait. Yes, sir.

*Mr. Crenshaw. Yes, and how successful are we? I mean, do we -- how is the DEA's relationship with the Mexican Government? Are they being cooperative?

*Mr. Strait. Well, on that one I will probably pivot, just because of my role within DEA. I am part of the 20 percent of the organization that has that regulatory role on domestic --

*Mr. Crenshaw. Okay, fine.

*Mr. Strait. -- on the domestic supply chain. But I do want to make one important point, and it is something that Dr. Jones made earlier.

You know, I think the biggest threat that we have noticed with opioid misuse has been this constantly evolving landscape, where we have gone from prescription drugs to heroin to synthetic drugs, which have included opioids and now nitazenes and other substances. And that will continue to be a problem. It has been the situation for my --

*Mr. Crenshaw. Excuse me if I can go over time just one second. So I listed three things, right: lack of resources, lack of authorities, target the cartels directly. You chose target the cartels directly, as, I think, the number-one missing element in being able to stop this. Is that --

*Mr. Strait. No, sir.

*Mr. Crenshaw. Okay. The other two are important, also?

*Mr. Strait. I apologize. I apologize. I am telling you that that is the number-one priority for our administrator at this point.

*Mr. Crenshaw. Okay.

*Mr. Strait. That is what we are focused on.

*Mr. Crenshaw. Okay. Well, that tells me something. Thank you.

And I yield back.

*Mr. Guthrie. The gentleman yields back. And Mrs. Trahan, you are ready?

Okay, Mrs. Trahan, you are recognized for five minutes for questions.

*Mrs. Trahan. Thank you, Mr. Chair.

Time and again, this committee has come together in a bipartisan manner to pass critical policies to address the addiction overdose crisis that has been plaguing our communities for far too long. At the end of last year we passed policies that break down barriers to buprenorphine access, as well as increased knowledge on how providers can help their patients who may be suffering with substance use disorder.

Now we must take this unique opportunity to hold -- to build on that progress, to strengthen our response to the ongoing addiction crisis, including increasing equitable access to all FDA-approved MATs, like methadone. The hearing

today includes a bipartisan bill I introduced with Representative Lori Chavez-DeRemer that authorizes a monitoring and education program regarding infections associated with illicit drug use.

Dr. Jones, can you please state the importance of this program, and how a program like this can help to break down the stigma associated with opioid use disorder?

*Dr. Jones. Thank you very much for the question.

We have seen over the last decade, certainly, increases in hepatitis C, hepatitis B virus, as well as outbreaks of HIV in communities across the country associated with injection drug use. And so the authorization and investment in expanding access to services not only to increase testing for viral hepatitis or HIV, expand vaccination for A and B, as well as referral to treatment services for, you know, antivirals that can cure hepatitis C or treat HIV or HIV prep, those are really critical services for people who inject drugs.

And often times that population is highly stigmatized and marginalized. And our work in this space is supporting health departments and community organizations to really meet

the moment where those individuals are through syringe services programs, through other programs in communities that can approach individuals with compassion and empathy who have often not wanted to engage with the health system because of stigma in the way that they have been treated.

So it is a really critical investment in reaching a very high-risk population not only for overdose, but also infectious disease transmission.

*Mrs. Trahan. I appreciate all of that, and it is something this committee will take into account.

So in early 2000, a company in my home state of Massachusetts paused its wastewater epidemiology work in opioids to focus on the COVID-19 pandemic, making the commonwealth a pioneer in measuring SARS-CoV-2 community infections in wastewater. Now this same company is expanding its wastewater platform as it shifts back to the opioid space to help communities better understand and respond to high-risk substance use at all community levels.

So, Dr. Jones, to you again, in your testimony you state that CDC works with state and local communities to ensure funded programs and resources are identifying and addressing

trends in the overdose landscape that are evident through data systems. I understand the CDC utilizes wastewater epidemiology data analysis to identify emerging infections within communities. How can wastewater epidemiology help to identify emerging substances related to illicit opioid use like fentanyl, and now Xylazine?

*Dr. Jones. Thank you for the question. It is certainly an active area of discussion within CDC, but also more broadly within the interagency and the executive branch about what is the role, how do we apply what we have learned through COVID and Mpox and other infectious disease outbreaks that might be useful in helping communities tap into wastewater surveillance as a component of the overdose crisis response?

I think we are still trying to work through what are the ethical and legal constraints, community acceptability, resources to do that work, and then how does it fit within the other data collection systems that we have. And we have prioritized, under our Overdose Data to Action program, emergency department data, mortality data, EMS data, which links the substances that are being used with the outcomes

that we are trying to prevent. So it does provide very actionable information for communities to understand what drugs are circulating, what harms are happening.

So we are trying to figure out, if we move in that direction with wastewater, how do we do it in the most optimal way that really gives communities information for action that they don't currently have.

*Mrs. Trahan. Sure. And given the example that, you know, you just raised related to wastewater epidemiology, how should we think about bolstering public-private partnerships to utilize data infrastructure that was put in place through COVID to improve our community responses to the ongoing addiction crisis?

What tools do you think we can leverage private investment in?

*Dr. Jones. I think it is an area for further discussion.

I mean, we certainly work with companies that have different data sources to help us understand and help communities understand the full mosaic of what is going on with substance use in communities. So data that looks at

prescribing trends for buprenorphine, data that looks at emergency medical services, ambulance runs in communities.

So I think we are trying to build out those public health and private-sector partnerships to help tell the story, and not recreate the wheel with new surveillance systems, but to leverage systems that already exist.

*Mrs. Trahan. Great. Well, thank you all for being here today. I really appreciate your responses.

And I yield back my time.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes Mrs. Harshbarger for five minutes for questions.

*Mrs. Harshbarger. Okay. Thank you, Mr. Chair. Thank you all for being here today.

Mr. Blum, my first question goes to you. It is a common practice among some insurance plans to use closed pharmacy networks, which only permits patients to get their medication from a specific pharmacy, and that is selected from a Pharmacy Benefit Manager. This practice can result in patients with a substance use disorder not getting their required treatment because the pharmacy can be difficult to

access, or -- especially in instances when the medications are distributed through specialty pharmacies. And this gap to a prescribed medication could lead patients to relapsing, or even worse.

And I know that some states are advancing policies that would require the PBMs to utilize any -- willing provider status is what it is called, and that is for serious mental health illnesses and substance use disorder medications to address the problem.

My question is, is this delay in timely fulfillment of substance use disorder medication something CMS is aware of, or have you looked into that?

*Mr. Blum. Thank you for the question.

We have certainly heard very similar concerns, and see very little evidence that by having closed pharmacy networks there is better clinical outcomes, there is more savings.

We are happy to work with you on ways for us to improve Medicare policies, Medicaid policies, but haven't seen data that suggests that we get better outcomes by having more narrow pharmacy networks.

*Mrs. Harshbarger. Okay, okay, we will try to help in

any way we can on that.

Mr. Strait, the SUPPORT Act provided resources and authorities to prevent illegal drug products from entering the U.S. supply chain via mail. However, you know, consumers are -- they are going to rely on the Internet to purchase various products, and that includes prescription medications. And the emergence of these illegitimate online pharmacies has really become a concerning issue. And I have been a pharmacist 36 years, so this is right up my alley.

These bad actors deceive these unsuspecting customers by selling counterfeit pills. Sometimes they are laced with fentanyl. And I know, Dr. Jones, when I was at CDC they were looking at opioid deaths, going back to see if there was fentanyl involved when I talked to the CDC director.

You know, it really it poses significant risks to people's health and safety. And to address the evolving challenge of corner drug stores shifting to online platforms, how do you suggest we effectively shut these digital drug dealers down?

And we know that they are dealing through Snapchat and TikTok. And, you know, being on homeland Security, I know

that that is how they recruit these drug dealers, basically.

*Mr. Strait. Congresswoman, I thank you for that question, because that is an important piece of the puzzle that we need to also solve.

*Mrs. Harshbarger. Yes.

*Mr. Strait. You know, what we have been saying at DEA is that social media actually represents the superhighway --

*Mrs. Harshbarger. Absolutely.

*Mr. Strait. -- for connecting a drug dealer with an unsuspecting American.

*Mrs. Harshbarger. Yes.

*Mr. Strait. And unfortunately, we see that happening every day. And I would say that we not only see it on the illicit side of our house, but then, to your point about some of these online intermediaries, we can also see how social media is being used to get new patients to seek controlled substances pursuant to a prescription that may not be being issued in the legitimate course of practice.

*Mrs. Harshbarger. Well, of course. That is why they are online trying to get it.

*Mr. Strait. So we are very, very concerned about that

issue.

*Mrs. Harshbarger. Yes, I would like to see numbers on that, too, you know, data.

Well, I have got a minute left. Mr. Coderre, SAMHSA has awarded billions of dollars in grants to treat opioid use disorders under the state opioid response grants. To my knowledge -- and you correct me if I am wrong -- SAMHSA is not tracking clinical outcomes like treatment retention rates, or whether patients stop using the illicit opioids, or whether or not those patients are getting back to work.

So I would like to ensure that the funds authorized and appropriated by Congress are used wisely, especially given we already have a broad network of effective programs for treating these opioid disorders. And I believe we need a greater focus on the effectiveness of these programs. You know, you have to measure outcomes, especially when they receive funding from us. And without tracking clinical outcomes, how can we assure that money is going to providers with the best clinical outcomes and highest likelihood by helping their patients achieve recovery?

*Mr. Coderre. Thanks so much for that question,

Congresswoman.

The state opioid response grants are critically important. The states rely on these resources to really expand treatment, prevention, and recovery support services. We do track outcomes through that program. I would be happy to get you the outcomes --

*Mrs. Harshbarger. Okay.

*Mr. Coderre. -- that we do track, and then work with the committee --

*Mrs. Harshbarger. Yes, that would be very --

*Mr. Coderre. -- to track things that we may not be tracking that you think we should be.

*Mrs. Harshbarger. Yes, fantastic. Because we need to know who is doing it right and who is not doing it right.

*Mr. Coderre. Absolutely.

*Mrs. Harshbarger. Okay. I think my time has expired, and I yield back, sir.

*Mr. Guthrie. The gentlelady yields back. The chair recognizes Dr. Ruiz for five minutes for questions.

*Mr. Ruiz. Thank you for holding this important hearing today as we are considering these programs that were

originally included in the SUPPORT Act in 2018, which built on the work done in the Comprehensive Addiction and Recovery Act before that.

It is sobering to note how long we have been working to tackle this crisis, which continues to evolve. And while I know we have made great strides to tackle this epidemic, the COVID pandemic and the surge of fentanyl have pushed us into another wave of the crisis, with fentanyl remaining the leading cause of death for U.S. adults ages 18 to 45. That is why it is critical to examine these programs and extend the ones that are working.

Substance use disorders don't just affect the person with the disorder; entire families feel the ripple effects, often suffering trauma as a result of their experiences. That is why, in the SUPPORT Act, we created the Interagency Task Force on Trauma Informed Care. We need to make sure that we are taking a holistic approach and treating the entire family appropriately in order to properly address the effects of this disease.

The purpose of this task force is to solicit input from on-the-ground experts and then provide recommendations,

including evidence-based best practices and a national strategy, to help children and youth who have experienced or are at risk of experiencing trauma resulting from substance use disorder.

As a doctor who came to Washington to advocate for and write policy to improve the health and lives of the communities that I serve, I can say firsthand that it is critical to include experts in the policy-making process. And by experts I mean people on the ground with lived experiences carrying out those policies every single day. Many things that we consider here in Congress sound like a good idea, and intentions are good, but there is nothing that can replace the value of real-life experiences in the policy-making process, real life experience to know what actually works, what actually doesn't work.

That is why this task force is so important. It includes input from the very people that need to be at the table as these decisions are being made: frontline providers; educators; mental health professionals; researchers; experts in infant, child, and youth trauma; and child welfare professionals. These are the people who should

be helping to shape the best practice recommendations.

And the work of the task force is not done, which is why it is important to extend their authority past its current expiration in September. That is why I introduced H.R. 4080, the Trauma Informed Care Task Force Reauthorization Act, with my colleague, Mr. Latta, to ensure the successful completion of this important work.

I understand that next month the task force is holding a meeting with stakeholders to present the status of their work on phase one of the operating plan of the National Strategy for Trauma Informed Care, and solicit their feedback and input to help inform their work, moving forward. The importance of stakeholder input cannot be overstated, and giving the task force more time to complete their mission is essential so that the process is not rushed and the final product is comprehensive and effective.

Mr. Coderre, what is the current status of the task force, and why is it necessary or beneficial to extend it?

*Mr. Coderre. Thanks so much, Dr. Ruiz.

You know, the SUPPORT Act really represented a huge step forward in integrating trauma informed care throughout the

Department of Health and Human Services public health activities. As you pointed out, the task force has been meeting regularly, and has been doing really important work creating an operating plan for the national strategy that exists on four pillars: best practices, research, data, and Federal coordination.

And so at the July meeting we expect to have the findings presented from phase one, the environmental scan, and so we are really looking forward to having the task force --

*Mr. Ruiz. And what is the goal of that meeting? Like, what -- how will it influence the work of the task force, moving forward?

So you have a presentation, but what do you want to do with it?

*Mr. Coderre. Well, the -- as I mentioned, they will present the findings from the environmental scan, which will be a roadmap for the task force going forward.

*Mr. Ruiz. Okay. And so there is a plan.

*Mr. Coderre. Correct.

*Mr. Ruiz. You are going to create -- okay. And what

can Congress do to assist the task force to help ensure its success?

*Mr. Coderre. Well, I think reauthorizing the task force would be the first step, and then working with us, as we find the recommendations from the task force, to help implement them.

*Mr. Ruiz. Thank you.

I yield back my time.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Dr. Miller-Meeks for five minutes.

*Mrs. Miller-Meeks. Thank you, Mr. Chair.

We are here today talking about reauthorizing the SUPPORT Act amid an opioid crisis that is now worse than ever. According to the latest CDC data, we have lost more than 110,000 Americans due to drug overdose deaths in 2022. It is estimated that 75 percent of these deaths involved opioids, and many of them fentanyl or fentanyl analogs, meaning that we lost 226 Americans every day to opioids.

To put this in context, 5 years ago, when Congress considered this legislation, we lost just over 53,000 Americans, or 146 a day, to opioid-related drug overdoses.

This means that rates of opioid-related drug overdoses have increased by 55 percent.

We need to approach our opioid crisis differently. The SUPPORT Act included important, well-intentioned efforts to help individuals and families in crisis. However, more needs to be done to prevent addiction, including minimizing unnecessary exposure to opioids.

Ninety percent of the acute pain patients receive opioids to manage their pain, whether they need them or not. Between 2011 and 2019, opioid prescriptions decreased by 40 percent, which is a good thing, from approximately 250 million to 150 million prescriptions dispensed. This is true across most payer audiences: Medicaid, private, and cash payments. However, among Medicare patients, opioid prescribing actually increased nominally.

Furthermore, Medicare's share of opioid prescribing during this time increased substantially from approximately 20 percent of the country's opioid prescriptions in 2011 to 35 percent in 2019. This represents a 75 percent increase in just under a decade. We clearly have some work to do in Medicare to make sure that patients have access to effective

pain relief agents, while also not unnecessarily exposing them to narcotic painkillers.

One opportunity to do this would be to enhance access to and use of non-opioid pain relief agents and also other things that look at pre-surgical treatment, whether or not someone should -- nothing by mouth for an entire time, adequate hydration. And I have seen that through places within my district.

Mr. Blum, can you detail CMS's support for policies to increase access to and availability of non-addictive pain management options?

How can my office work with you to make sure that patients have robust access to these approaches?

*Mr. Blum. Thank you for the question, Congresswoman. We too support the goal to ensure that Medicare beneficiaries have the full spectrum of treatment.

The Part D Medicare program today monitors use very carefully to ensure that we don't have inappropriate use. That program today works very well. We are happy to follow up to learn more how CMS programs can do better.

*Mrs. Miller-Meeks. Thank you, and I will also keep you

apprised of what is happening within my district and the unique approaches they are taking, as well.

Deputy Administrator Blum, H.R. 824, the Telehealth Benefit Expansion Act, would increase the ability of employers to offer telehealth-only coverage by accepting it from various laws that apply specifically to health insurance. During the pandemic employers did this to increase access to care for employees that did not have access to major medical insurance, like seasonal and part-time workers. I have a technical question on the bill.

Employer health plans are regulated through several different statutes, some of which have different requirements that are applied and enforced differently. For example, the Public Health Service Act includes requirements onto fully insured employer plans, small employer plans, and individuals that purchase major medical insurance directly from the exchanges.

The ERISA statute includes requirements onto self and fully insured plans, some of which are different than the Public Health Service Act's requirement. If the bill were only to amend the ERISA statute, would fully insured

employers and small employers for purchase through the exchanges be able to offer telehealth-only plans as an accepted benefit?

*Mr. Blum. I don't believe so, but I am happy to follow up to better understand your question.

*Mrs. Miller-Meeks. We would certainly appreciate the follow-up, and you can do that written to the subcommittee.

[The information follows:]

**********COMMITTEE INSERT**********

*Mrs. Miller-Meeks. Thank you, Mr. Chair. I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. That completes all the members for questions.

We do have -- I would have thought you are a member, you are very participatory in this, I know, this issue because you have worked hard, and traveled to Gettysburg, and did everything.

So it gives me joy to recognize my good friend, Mr. Tonko, for five minutes.

*Mr. Tonko. Thank you, Chair Guthrie, and thank you, Ranking Member Anna Eshoo, for your work with me on this topic, and for waiving me on for today's hearing, and I thank my friend and colleague, Representative Armstrong, for working with me on several of the bills before us today. And thank you for our experts at the table as witnesses for joining us.

Our country has a mental health crisis, a substance use crisis, and a fentanyl crisis. And so it requires us -- I think the presence of everyone in this room today speaks to that concern, and want to have a resolve. So my reentry bill

needs to be done. It is a very, very impactful audience that is affected by that legislation, and we need to save their lives.

So when I hear of IMD exclusion, not requiring any kind of adjustment of a funding stream, but I hear it for the reentry bill, I get concerned. When I hear suspension versus termination discussion -- I didn't pull 30 days out of the air. They need at least 30 days to get themselves tethered to a system and to be strong enough as they leave that incarcerated system -- incarceration system to be able to survive and beat the statistics.

And when I joined my colleagues in Gettysburg, I appreciated that it was an honorable offering they made to join them at the hearing. And we heard from the law enforcement community that this is a very important tool.

So thanks to the bipartisan work this committee has done over the years, five years ago, with the SUPPORT Act, states can now apply for a demonstration program to use Medicaid for eligible services for justice-involved individuals returning to their communities 90 days pre-release.

Currently, Federal statute, as we know, prohibits any

form of Federal health coverage for incarcerated individuals, except under very limited circumstances. In many states, Medicaid coverage is immediately terminated when someone is sent to a correctional setting. And in the rest, coverage is suspended, and it takes various lengths of time to restart it. This creates a serious coverage gap when individuals are released, as they often have no access to health care or addiction treatment during a stressful and dangerous time.

Mr. Blum, I applaud CMS for moving forward with the demonstration program, which was a result of this concern. And through my Reentry Act I hope to codify reentry policy.

I also am proud to champion the Due Process Continuity of Care Act with my friends, Representative Trone, Turner, and Rutherford, who also lead Reentry with me. Due Process would make certain that pre-trial detainees are not kicked off Medicaid prior to ever being found guilty of a crime.

So CMS has said extending Medicaid eligibility prior to release can improve connections to community-based providers. Can you talk about why that is important?

And additionally, why does CMS believe that the period post-incarceration is such a critical time to receive

treatment and coordination of care?

*Mr. Blum. Thank you for the question. We hear from states, we hear from experts that one of the best ways that we can prevent relapse is to ensure continuity of coverage. And so we are very supportive to the work that you have put forth. We are very excited to work with more states to figure out ways for us to continue coverage.

*Mr. Tonko. Thank you. And with the recent passage of my Mainstreaming Addiction Treatment Act, or MAT Act, we have had a dramatic expansion of the United States' health care system's ability to treat opioid use disorder with buprenorphine, increasing the number of medical professionals who can prescribe buprenorphine for opioid use disorder from 130,000 to 1.8-plus million with the removal of the X waiver. That is a lot of hope, a lot of lives saved.

I sent the DEA administrator a bipartisan letter with 20-plus members in March of this year asking several questions about increased access to buprenorphine, and specifically asked for the DEA to issue additional guidance to all registrants to ensure patients get access to this lifesaving medication. To date, I have not received a

response.

I also requested a meeting to follow up on this, and so far nothing has been set up.

I am hearing repeatedly from emergency physicians that when they write prescriptions for buprenorphine, patients are getting told at pharmacies that it is not available. In many cases, the pharmacies are saying they are cut off for the month, and are too close to their limit. In some cases, patients give up after going to multiple pharmacies. This is simply unacceptable, that someone would get so close to accessing addiction treatment and then, at one of the last steps, be turned away. I believe that DEA must play a role in clearing up this confusion.

So when will the DEA be responding to my letter?

*Mr. Strait. I am going to take that back to our leadership team, and get you an answer to that question, sir.

But I do want to also --

*Mr. Tonko. Well --

*Mr. Strait. -- just give a quick shout-out to our folks at SAMHSA. We have been dealing with the buprenorphine access issue at the pharmacy level for over a year and a half

now.

*Mr. Tonko. And Mr. Chair, if you will indulge me, when will DEA issue additional guidance that sends a strong message to the community that DEA wants access to addiction medication in every community?

*Mr. Strait. I would argue that we have already sent that message out, and we will repeat that message again and again.

*Mr. Tonko. And will you --

*Mr. Strait. -- a year ago.

*Mr. Tonko. And will you provide additional clarification to distributors, pharmacists, providers so they better embrace their role to expand access to addiction treatment? We want that 1.83 million achieved.

*Mr. Strait. You are 100 percent correct. So do we. And actually, we have been working with our manufacturing and distributor communications, and communicating just those points.

*Mr. Tonko. Well, thank you. I think this is a time for us to come together, not deal with politics, but with facts to come together, to make certain we respond to the

needs of those that are incarcerated, struggling with the illness of addiction. Let's not start negotiating other terms around this issue that deals with the most vulnerable audience. And I would hope today we would hear a go-forward-and-get-it-done attitude. We need to address the reentry bill.

And with that, Mr. Chair, I yield back.

*Mr. Guthrie. Thanks. The gentleman yields back. All questions have been asked, and the time has expired for asking questions.

So I will move to -- I will ask unanimous consent to insert in the record the documents included on the staff hearing documents lists, including both minority and minority [sic] information.

*Ms. Eshoo. So moved, Mr. Chairman.

*Mr. Guthrie. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. And I will remind the members that they have 10 days to submit questions for the record -- so you could receive further questions -- and ask the witnesses to respond promptly. Members should submit their questions by the close of business July the fifth.

Yes?

*Mr. Tonko. Mr. Chair, if I might, I thank you for allowing me to waive on, and you and the ranking member have been most helpful. Let's get this reentry done, and let's solve the crisis nationally.

*Mr. Guthrie. Thank you. Thank you for your kind words.

So members will submit their questions by close of business on July 5.

So without objection, the subcommittee is adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]